



Children's Health and Behavioral Health Medicaid System Transformation

Children's Home and Community Based Services Manual

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Send questions to BH.Transition@health.ny.gov



Department
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Mental Health

Office of Addiction
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Office of Children
and Family Services

Office for People With
Developmental Disabilities

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INTRODUCTION

OVERVIEW

Home and Community Based Services (HCBS) are designed to allow children and youth to participate in developmentally and culturally appropriate services through Medicaid. New York State (NYS) is committed to serving individuals in the least restrictive environment possible by providing services and supports to children/youth and their families at home and in the community.

HCBS are designed for children/youth who, if not receiving these services, would require the level of care provided in a more restrictive environment such as a long-term care facility or psychiatric inpatient care, as well as children/youth stepping down from a long-term care facility or psychiatric inpatient care.

The Children's Medicaid System Transformation for individuals under the age of 21 includes the alignment of the following NYS children's waivers previously accessible under the authority of the 1915(c) amendment of the Federal Social Security Act: Office of Children and Family Services (OCFS) Bridges to Health (B2H) Serious Emotional Disturbance (SED), B2H Developmental Disabilities (DD), B2H Medically Fragile (MedF), the Office of Mental Health (OMH) SED Waiver, Office for People With Developmental Disabilities (OPWDD) Care at Home (CAH) IV Waiver, and the Department of Health (DOH) operated Care at Home (CAH) I/II Waiver.

The Office of Addiction Services and Supports (OASAS), OCFS, OMH, OPWDD, and DOH have collaborated to create an aligned service array of HCBS benefits for children meeting specific diagnostic and functional criteria. The [1915\(c\) Children's Waiver and 1115 Medicaid Redesign Team \(MRT\) Waiver](#), with approval from the Centers for Medicare and Medicaid Services (CMS) in 2019, provides NYS the authority for these HCBS benefits. The waiver includes person-centered planning requirements and specifies transitional coverage requirements for children/youth enrolled in any of the aforementioned 1915(c) waivers at the time of transition.

HCBS/Level of Care Eligibility Determination includes:

- 1) Target Population (TP) criteria,
- 2) Risk factors (for some TP),
- 3) Functional criteria, and
- 4) Medicaid eligibility.

This Manual defines the specific composition of each service while outlining provider roles and responsibilities. Additionally, it is a reference tool for Health Homes (HH), Health Home Care Managers (HHCM), HCBS Providers, Medicaid Managed Care Plans (MMCPs), and the State's Independent Entity of Children and Youth Evaluation Services (C-YES) regarding care management, the service delivery system, and Medicaid eligibility determination and impact to service delivery. All HCBS benefits are applicable in any home or community setting meeting federal HCBS settings requirements inclusive of the child/youth or family environment, with some exceptions noted in this Manual.

This Manual also provides an outline of performance measures that are pertinent to the HHCM/C-YES and HCBS Providers (see Appendix J. The performance measures noted in the Appendix J are not inclusive of all performance measures required by the Children's Waiver. For a full list of all required reporting measures, please see the most up to date Children's [Waiver amendment](#).

Vision and Goals

HCBS are designed to offer support and services to children/youth in non-institutionalized settings that enable them to remain at home and in the community or for children/youth being discharged from an institutional setting who require these services to safely return to their home and community. HCBS provides a family-driven, youth-guided, culturally and linguistically appropriate system of care that accounts for the strengths, preferences, and needs of the individual, as well as the desired outcome. Services are individualized to meet the physical health, developmental, and behavioral health needs of each child/youth. Participants have independent choice among an array of service options and providers. These services are provided in a flexible, complimentary package that evolves over time to meet the changing needs of the child/youth.

HCBS are intended to be provided to a child/youth and family in their home and/or the community. The array of services is intended to assist children/youth in being successful at home, in school, and in their other natural environments to help maintain them in their community and avoid higher levels of care and out-of-home placements.

It is the mission of NYS and its child and family serving agencies to improve health and behavioral health care access and outcomes for individuals served while demonstrating sound stewardship of financial resources.

PROVIDER REQUIREMENTS

Overview

Service providers delivering Children's Home and Community Based Services (HCBS) must meet the following requirements:

- Be a qualified provider as described in this *Children's Home and Community Based Services Manual* and any subsequent updates
- Be in good standing according to the standards of each agency by which it is licensed, certified, designated, or approved
- Possess, acquire, and retain any State licensure, certification, authorization, or credential when required
- Be a fiscally viable agency and maintain fiscal integrity
- Be enrolled as a NY Medicaid Provider with an active provider identification number prior to commencing service delivery
- Submit an application to and be designated by the NYS Children's Provider Designation Review Team
- Have appropriate agreements in place for any outsourced administrative functions, if applicable
- Be compliant with the HCBS Settings Rule
- Have at least one contract with a Medicaid Managed Care Plan
- Sign and be compliant with the Children's HCBS Provider Designation Attestation

Designated HCBS Provider Attestation

The Children's Waiver requires provider designation to be renewed at least every three years. Providers will be required to complete the [Designated Home and Community Based Services \(HCBS\) Provider Attestation](#) as part of the re-designation process to confirm they are familiar with the requirements of the Children's Waiver and will adhere to the standards, policies, procedures, and guidance put forth by NYS regarding the HCBS Children's Waiver.

Newly designated providers must complete the Designated Home and Community Based Services (HCBS) Provider Attestation and return it to the NYS Children's Provider Designation Interagency Review Team within 30 days of receipt. If the provider's designation is altered (i.e. added/removed site(s), service(s), etc.), an updated Provider Attestation is not required. Providers must adhere to all requirements outlined in the attestation regardless of any designation alterations, unless the alterations result in a de-designation from all HCBS.

Designation

The Children's Designation process is a multi-State agency process that includes OMH, DOH, OASAS, OCFS, and OPWDD (i.e., the NYS Children's Provider Designation Interagency Review Team). These agencies provide guidance to providers who intend to become NYS HCBS providers serving children/youth under the 1915(c) Children's Waiver.

Any service provider delivering HCBS must be designated to do so by the NYS Children's Provider Designation Interagency Review Team. To become designated, the provider:

1. Must meet the qualifications as outlined in this Manual and be identified as a child serving agency or agency with children's behavioral health and health experience and;

2. Be an OMH, OASAS, OCFS, DOH, or OPWDD provider, that is licensed, certified, designated, and/or approved by OMH, OASAS, OCFS, OPWDD, or DOH or its designee to provide comparable and appropriate services referenced in the service definition or;

3. Who are not currently licensed, designated, or certified by any of the State agencies must follow the [Designation Policy for Non-Licensed/Non-Certified Providers](#).

NYS will initially verify provider designation status through the web-based online portal system, assuring providers are approved and active before they are authorized to provide waiver services. Provider designation will be recertified at least every three

years and at the discretion of DOH. Additional information on provider designation can be found in the [HCBS Provider Designation and Re-designation Procedure](#).

Information on gaining access to the Children's Waiver Provider Designation online application is available within the [Obtaining Access to the New York State Children and Family Treatment and Supports Services \(CFTSS\)/HCBS Designation Application](#). HHs are also designated and re-designated by NYS and must adhere to the [Health Home Standards and Requirements](#).

Re-Designation

The 1915(c) Children's Waiver requires that provider designation is reverified at least every three years. Designated providers must comply with State requests for information to confirm compliance with Children's HCBS designation. Re-designation for currently designated providers is a State-led process. The State will notify designated providers when they are required to re-designate as a provider of Children's HCBS.

Providers that have been de-designated but wish to become re-designated as a Children's HCBS provider must complete a Children's HCBS Provider Designation application. Once the re-designation application has been reviewed, the provider will receive a Children's HCBS Re-Designation Letter that indicates approved services by site. Re-designated agencies will also be required to complete the [Designated Home and Community Based Services \(HCBS\) Provider Attestation](#) and return it to the NYS Children's Provider Designation Interagency Review Team within 30 days of receipt.

De-Designation

When an agency has made a decision to de-designate from a service, site, or county, a formal request must be submitted in writing to the NYS Children's Provider Designation Interagency Team at (OMH-Childrens-Designation@omh.ny.gov).

New York State can also decide to de-designate an agency providing HCBS for some services or all services due to non-compliance to the attestations, policies, procedures, and/or claiming requirements.

If an HCBS provider determines to de-designate, they must notify the NYS Children's Provider Designation Interagency Team and establish a transition plan for any and all children/youth being provided services. De-designation cannot occur until all children/youth receiving services from the agency have been fully transitioned to another designated service provider or no longer require services as determined in collaboration with the child/youth's HHCM/C-YES. De-designation would occur only

after the NYS Children's Provider Designation Interagency Team has confirmed that the affected children/youth enrolled with the agency have been appropriately transitioned.

Participation in State-led annual case reviews and submission of all required reporting documents remain requirements for providers that have provided services within the review period (i.e., Waiver year), even if the provider has been de-designated.

Medicaid Enrollment

For more information

Refer to the [Children's HCBS Provider Designation and Re-designation Procedure](#).

Prior to the delivery of HCBS, providers must be Medicaid enrolled. Providers who are not already Medicaid enrolled must complete the [NY Medicaid Provider Enrollment Form](#).

Each provider delivering these services must be enrolled as a Medicaid provider with an active provider identification number and Category of Service (COS): 0268. A list of provider types and the application can be found on the [eMedNY website](#); questions can also be directed to the eMedNY Call Center at 1-800-343-9000.

Electronic Visit Verification (EVV)

For more information

Regarding the process for provider initiated and state initiated de-designation can be found in the [HCBS Children's De-Designation Procedure](#).

All Providers and Fiscal Intermediaries (FIs) who provide Medicaid Personal Care Services (PCS) and Home Health Care Services (HHCS) are required to utilize an EVV system to capture services that begin or end in the consumer's home. EVV applies to both Fee-for Service (FFS) and Medicaid Managed Care (MMC) services.

The federal [21st Century Cures Act](#), signed into law on December 13, 2016, requires all state Medicaid programs to implement an EVV system for PCS by January 1, 2021 and HHCS by January 1, 2023. As such, DOH required providers of Medicaid-funded PCS to select and implement compliant EVV systems that meet the requirements of the 21st Century Cures Act by January 1, 2021. Providers of Medicaid-funded HHCS will be required to select and implement compliant EVV systems by January 1, 2023.

Additional Information can be found in the following guidance and policies:

- [EVV Section on DOH Website](#)
- [EVV Program Guidelines and Requirements](#): provides an overview of the NYS EVV Program, providers that are subject to EVV, program and policy requirements, technical system requirements, and steps on how to begin working with DOH
- [Considerations for Selecting an EVV System](#)
- [State's Model Choice for EVV](#): letter submitted to the Centers for Medicare and Medicaid Services (CMS) on April 10, 2020 describing NYS progress towards implementation

For the Children's Waiver, EVV requirements **ALWAYS** apply to Community Habilitation and **MAY** apply to Respite services. EVV requirements do not apply to Day Habilitation. Children's HCBS providers that are designated or want to be designated for Community Habilitation and or Respite services must self-assess as to whether they meet the EVV criteria and, if necessary, take steps internally to become EVV compliant. Children's Waiver HCBS providers that might also serve the OPWDD Waiver will need to comply also with OPWDD Guidance.

After self-assessment, some HCBS Respite providers will determine that they do not meet EVV requirements for *any* of the HCBS-enrolled children/youth they serve, while other HCBS Respite providers may meet the EVV requirement for *some or all* of the enrolled children/youth they serve.

Since EVV may be applicable to Planned and Crisis Respite, Respite providers **must** complete the [Children's Waiver EVV Declaration Form](#) to confirm they understand the EVV requirements and have determined if they meet EVV requirements. All Planned and Crisis Respite that meet EVV, AND all Community Habilitation providers, will be required to complete an EVV Attestation via [eMedNY](#) ensuring they have obtained the appropriate systems for Electronic Verification.

For more information

For designated HCBS providers can be found in the March 8, 2019 NYS memo [Medicaid Provider Enrollment for Individual Practitioners and Designated Agencies](#)

CMS Final Rule on HCBS Settings

Background and Overview

In 2014, Centers for Medicare & Medicaid Services (CMS) published [new requirements](#) that settings where children/youth receive HCBS must meet to remain eligible for Medicaid payment. These updated standards are designed to ensure these settings protect the rights and choices of children/youth receiving HCBS and promote integration in and full access to the community. By design, HCBS are provided in home and community-based settings; for this reason, HCBS providers are required to demonstrate compliance with these standards (see Appendix B for the detailed standards).

DOH Compliance Process

DOH assesses compliance with HCBS settings requirements for both existing designated providers and those seeking designation.

All designated Children's Waiver HCBS providers will need to be in compliance with the settings requirements of the Final Rule by March 17, 2023. For current sites the State believes overcome the presumption of institutionalization and meet the requirements of the Final Rule, the State will submit to CMS information or documentation ensuring all individuals served in that setting are afforded the degree of community integration required by the Final Rule. Sites that are not able to come into compliance by this date will be de-designated as a Children's Waiver HCBS provider.

Additionally, during the annual case review and audit, HCBS providers will be continually monitored to ensure continued compliance with the Final Rule, including person-centered service planning and freedom of choice for participants.

For new providers seeking designation to provide HCBS, NYS will conduct a review of the provider to ensure compliance with the HCBS Settings Rule through the following steps:

- Provider self-assessment
- Documentation review of policies/procedures
- Potential site visit

HCBS Settings Rule Resources

Please refer to Appendix B and the [DOH website](#) for more information about the CMS Final Rule. CMS also has an [HCBS Requirements Compliance Toolkit](#).

Consolidated Fiscal Report

The Consolidated Fiscal Report (CFR) is a standardized reporting method accepted by state agencies (OASAS, OMH, OPWDD, SED, DOH and OCFS), consisting of

schedules which, in different combinations, capture financial information for budgets, quarterly and/or mid-year claims, an annual cost report, and a final claim.

HCBS Designated provider agencies must submit an annual Consolidated Fiscal Report (CFR) following the guidelines provided in the [CFR Manual](#). HCBS is reported on the CFR under the auspices of DOH.

Criminal History, Background Checks, and Training Requirements

Required Clearances

The 2018-2019 Enacted Budget includes statutory requirements (Chapter 57 Laws of 2018) related to criminal history record checks, mandated reporter requirements, Statewide Central Register Database checks, and Staff Exclusion List checks for HHCMs and children's HCBS providers. The statute requires that HHs and Care Management Agencies (CMA) that provide care management to enrollees under age 21 and HCBS providers authorized under the 1915(c) Children's Waiver conduct the following on prospective employees:

- 1. Staff Exclusion List (SEL) through the NYS Justice Center for the Protection of People with Special Needs (Justice Center)**

The SEL is a Statewide Register maintained by the NYS Justice Center. The SEL contains the names of people found responsible for serious or repeated acts of abuse and neglect. The SEL check is required for all newly hired staff that will have regular and substantial contact with individuals under the age of 21. The SEL should be completed prior to all other required background checks for practical purposes.

- 2. Criminal History Record Checks (CHRC) through DOH**

The CHRC is a fingerprint-based, national FBI criminal history record check. CHRC is required for HCBS provider employees who provide direct care to members under the age of 21 (with [limited exceptions](#)). A provider must immediately, but no later than 30 calendar days after the event, notify DOH when:

- an individual is subject to CHRC via 103 submission and
- an individual is no longer subject to CHRC via 105 termination
 - Terminations include when an employee is no longer subject to CHRC; is no longer employed by the provider; employee death; or when a prospective employee is no longer being considered by the provider.

Upon receipt of the request for fingerprint (LiveScan), an appointment must be scheduled for the employee to be fingerprinted, along with indication of the method of payment.

3. Statewide Central Register (SCR) Database Check through OCFS

The SCR maintains a database of records of child abuse and maltreatment reports. The purpose of the Database Check is to find out if a prospective employee of a HCBS provider is a confirmed subject of an indicated report of child abuse or maltreatment. The SCR Database Check is required for those employees that will have regular and substantial contact with members, which includes but is not limited to HCBS providers.

Please refer to the [Background Check Requirements for HCBS Providers](#) policy for more details on scope, timeline, potential exemptions, and processes for each of these three types of clearances.

Mandated Reporter Requirements

HCBS providers and other applicable agency employees are mandated to report suspected child abuse or maltreatment, per NYS Social Services Law 413.

OCFS has information and registration links for free [Mandated Reporter Training](#) available on its website.

Training Requirements

The HCBS provider Human Resources staff must receive training on these requirements to ensure that staff receive the appropriate required clearances and to ensure that the HCBS provider is in compliance.

Each HCBS provider agency must maintain documentation indicating that all staff who provided HCBS during the Waiver Year (including those staff no longer employed by the agency) meet all training, qualifications, and required employment check requirements based upon the designation of the agency and the service provided by the staff member. Designated HCBS provider agencies will be required to submit proof of this documentation to the State on at least an annual basis.

This information is required to be reported to NYS DOH as part of the waiver annual case review and audit to meet performance measures within the Children's Waiver and reported to CMS.

Attestation for Foreign Education Documents

HCBS designated provider agencies that employ staff who have obtained their education outside the United States must complete the [Use of Foreign Education](#)

[Documents to Verify HCBS Staff Qualification Requirements](#) attestation for each applicable staff member. This attestation should be kept in the employee's file along with a copy of the relevant documentation.

HCBS ELIGIBILITY AND ENROLLMENT

Overview

To receive HCBS under Medicaid, a child/youth must be determined eligible based on meeting Target Population, risk factors, if applicable, and functional criteria measured by the HCBS/LOC Eligibility Determination. Only HHCMs or C-YES can determine HCBS/LOC Eligibility Determination; for some Target Populations, the assistance from the OPWDD DDRO is necessary for the HCBS/LOC eligibility determination.

Children/youth receiving HCBS through enrollment in a 1915(c) Medicaid Children's Waiver will have continued access to HCBS for as long as the child/youth continues to meet the eligibility criteria for the 1915(c) Medicaid Children's Waiver as listed below.

Children/youth who are eligible and appropriate for HCBS must have a physical health, developmental disability, and/or mental health diagnosis with related significant needs that place them at risk of hospitalization or institutionalization, or that HCBS is needed for the child/youth to return safely home and to their community from a higher level of care. (Institutionalization refers to children/youth at risk of being admitted to a higher level of care such as out-of-home residential settings, hospitalization, ICF-I/ID, or nursing facility).

Children and youth must be under 21 years old and eligible for Medicaid to receive Children's HCBS. Children's HCBS eligibility is comprised of three components: 1) target criteria, 2) risk factors, if applicable, and 3) functional criteria.

The HCBS eligibility groups are as follows:

Level of Care (LOC): children/youth that meet institutional placement criteria.

There are four subgroups for children/youth within the LOC group:

1. Serious Emotional Disturbance (SED)
2. Medically Fragile Children (MFC)
3. Developmental Disability (DD) and Medically Fragile
4. Developmental Disability (DD) and Foster Care

The services described in this document are accessible to eligible children/youth once a Plan of Care (POC) is in place. Further information regarding the POC can be found in the [Children's HCBS POC Workflow Policy](#).

To access Children's HCBS, a child/youth must meet LOC criteria (target criteria, risk factors, if applicable, and functional limits) using the HCBS/LOC Eligibility Determination which is housed within the Uniform Assessment System (UAS) along with the Child and Adolescent Needs and Strengths – NY (CANS-NY) assessment. Only a HHCM, C-YES, or the OPWDD Developmental Disabilities Regional Office (DDRO; refer to the [DDRO Manual for Children's Waiver](#) for additional information) are given access in the UAS to complete the HCBS/LOC Eligibility Determination. During this evaluation and assessment, the care manager must maintain regular contact with the child/family.

Upon signing and finalizing the HCBS/LOC Eligibility Determination within the UAS, the HHCM/C-YES assessor will be presented with an outcome of either HCBS/LOC eligible or not HCBS/LOC eligible, for the identified Target Population. The assessor MUST sign the UAS Outcome report to lock the HCBS eligibility determination and if found eligible, trigger the 12 months (365 days) of eligibility. Additionally, this trigger will send a report to DOH Capacity Management system to add the Recipient Restriction Exception (RR/E) Code K-codes to the child's/youth's Medicaid file demonstrating that the child/youth is eligible and enrolled in the Children's Waiver and can receive services. If the K-codes are not placed on the child/youth's Medicaid file, the HCBS provider cannot provide services and or get paid for services provided. Collaboration between the HCBS provider and HHCM/C-YES is necessary to ensure proper enrollment of the member and the ability to receive services. HCBS providers should verify within eMedNY or ePACES K-codes monthly prior to providing services.

The HHCM/C-YES will send the child/youth a **Notice of Decision**, which will document the outcome of the HCBS/LOC Eligibility Determination and provide information on State Fair Hearing rights. HHCMs/C-YES must notify the child/youth of the HCBS/LOC eligibility determination within 3 – 5 business days of determining the eligibility outcome.

The HCBS/LOC Eligibility Determination is an annual (12 month) determination. The annual determination date does not change according to the CANS-NY completed for the Health Home Serving Children (HHSC) program. Once the HCBS/LOC Eligibility Determination outcome is complete within the UAS, it remains active for one year from the date of signature and finalization, with three exceptions:

1. Significant life event (as noted below)

2. In the event that a child/youth that has been determined HCBS/LOC eligible and initially declines HCBS, but later requests HCBS, or if a child has been determined HCBS/LOC eligible but has been placed on a waitlist due to capacity limitations of the Children's Waiver. A new HCBS/LOC Eligibility Determination is required if an approved/active HCBS/LOC Eligibility Determination is not utilized within six months from the date of the HCBS/LOC Eligibility Determination outcomes.

3. If the child/youth is placed in a restrictive setting i.e., hospitalized or institutionalized for longer than 90 days and is disenrolled from the Waiver (as noted below)

If a child/youth is found HCBS/LOC ineligible and there is a change in circumstances, the child/youth can be reassessed at any time, as there is no wait period between assessments.

The target criteria, risk factors, if applicable, and functional limits must be documented in the UAS. Children/youth seeking HCBS who are not otherwise eligible for Medicaid (e.g. income and resources are above Medicaid eligibility allowances) should be referred to Children and Youth Evaluation Services (C-YES) and must meet a needs-based criterion for Medicaid eligibility determination via the following process:

- C-YES must complete the HCBS/LOC Eligibility Determination
- If found HCBS/LOC eligible, C-YES will assist families in completion of the Medicaid application and submission to the Local District of Social Services

(LDSS) or New York City (NYC) Human Resources Administration (HRA) to determine Medicaid Eligibility

- Once Medicaid is established, referral to appropriate care management will be completed by choice of the child/youth/family

HHCM or C-YES must retain the letter of notification, LOC eligibility determinations, home assessments, plans of care, and all other information pertaining to the child/youth's eligibility determination, enrollment and continued eligibility for the Waiver in the applicant's file.

This information must be retained for the duration of the child/youth's enrollment in the Waiver and for at least six years after the child/youth's 21st birthday for possible post-audit and evaluation by either state or federal agents.

For more information regarding HCBS requirements for independent assessment, see [Section 1915\(i\)\(1\)\(F\) of the Social Security Act](#).

For further information, refer to the [HCBS Waiver Enrollment Policy](#).

Please refer to Appendix G for further information regarding the impact of Medicaid Family of One budgeting and Spenddown on HCBS eligibility and care management.

Please refer to Appendix K for further information regarding K-Codes.

NOTICE OF DECISION

Once the Children's Waiver eligibility determination is complete, the HHCM/C-YES will send the child/youth/family a [Notice of Decision](#) (NOD) form.

Expectations for the Completion of NOD – Enrollment or Denial

The HHCM/C-YES must issue an adequate NOD to accept or deny an application for Waiver enrollment within 3 – 5 days of the HCBS LOC/Eligibility determination. There should be documentation to support the enrollment/denial decision. The member has 60 days from the date of the Notice of Decision to request a Fair Hearing from the Office of Temporary and Disability Assistance (OTDA). Fair Hearing rights are located on page 2 of [DOH-5287 form](#). HHCMs/C-YES staff are expected to review the entire form with the member and their family. Care managers and providers should know the process for Fair Hearings as well as who to contact in the event the family is interested in pursuing a Fair Hearing.

Further information regarding the Fair Hearing process is outlined in the [Health Home Notices of Determination and Fair Hearing Process](#) policy.

Expectations for the Completion of NOD – Discontinuance

The HHCM/C-YES must issue an adequate and timely NOD to discontinue services. The [Notice of Decision for Discontinuance](#) should be sent out within 1-2 business days of the decision made by the HHCM/C-YES, the lead HH, HCBS provider, and other care team members. The member has 10 business days from receiving the NOD of discontinuance to ask for a Fair Hearing and receive continuing aid until a decision has been made by OTDA. If the member files for continuing aid, the HCBS provider must continue to provide services to the member until the results of the Fair Hearing are determined. The member's Care Manager should inform the HCBS provider(s) of pertinent information concerning any changes in service eligibility and, if the results of the Fair Hearing support the decision to discontinue services, then the HHCM/C-YES should begin transition planning and documentation to support that decision. The Notice of Decision for Discontinuance is found [here](#).

Note: The member has 60 days from the date of the Notice of Decision to request a Fair Hearing from the Office of Temporary and Disability Assistance (OTDA). Fair Hearing rights are located on page two of DOH-5287 form. HHCM/C-YES are expected to review the entire form with the member and their family.

Additional Reasons for NOD Forms

- If child/youth lose Medicaid, the LDSS will send NOD and the HHCM/C-YES will work with family to reestablish Medicaid; if the child/youth is eligible for HCBS, the HHCM/C-YES will work with the family and LDSS/HRA to reestablish Medicaid.
- If the child/youth is HCBS LOC eligible but no slot is available, the family will receive a NOD from the HHCM/C-YES and when a slot is available, the HHCM/C-YES will send the family a letter notifying them of the available slot.
- For children/youth in the Target Populations DD Med Frag or DD foster care, please refer to the [OPWDD DDRO Manual for Children's Waiver for guidance for each applicable situation](#).

Fair Hearing

If a child/youth and/or family does not agree with the decision indicated on the [Notice of Decision](#) form, they have a right to a conference and/or Fair Hearing. Upon receiving a copy of a NOD from the HH, the member has 60 days to request a Fair Hearing if they disagree with the determination as stated on the NOD. Decisions regarding Medicaid eligibility and the provision of waiver services (e.g., denial/reduction of services; child/youth was not offered choice of services) can be addressed through the Fair Hearing process. Care managers should explain these rights and the process for requesting them to the participant and their parent/guardian/legally authorized representative.

Information regarding the Right to a Conference and the right to Request a Fair Hearing are located on page 2 of the [Notice of Decision](#) form and [Health Home Notices of Determination and Fair Hearing Policy](#).

HCBS Eligibility Reauthorization

The 1915(c) Children's Waiver for HCBS requires an annual (12 month) HCBS/LOC Eligibility Re-determination to be completed for the child/youth to remain in the Waiver and continue receiving Waiver services.

All HHs, HH CMAs, and C-YES should audit their records of Waiver-enrolled children/youth to ensure all HCBS LOCs are up to date and completed timely. HHCM/C-YES staff should begin gathering annual re-determination supporting documentation two months prior to the re-determination due date to ensure enough time to complete the annual HCBS LOC within the required timeframe (365 days).

Note: For children/youth requiring an ICF-IDD LOC from OPWDD Developmental Disabilities Regional Office (DDRO), it is important to remember this process can take up to a month to complete. Timely and on-going communication with the DDRO is encouraged.

Significant Life Event

If a significant life event occurs for a child/youth while receiving HCBS, a new HCBS/LOC Eligibility Determination may be needed. A significant life event is something that occurs in a child's/youth's life that impacts their functioning, daily living situation, or those that care for the child/youth. Reasons for HCBS/LOC Reassessment Change of Circumstances include:

- Significant change in child/youth's functioning (including increase or decrease of symptoms or new diagnosis)
- Service plan or treatment goals were achieved
- Child/youth admitted, discharged or transferred from hospital/detox, residential setting/placement, or foster care
- Child/youth has been seriously injured in a serious accident or has a major medical event
- Child/youth's (primary or identified) caregiver is different than on the previous HCBS/LOC
- Significant change in caregiver's capacity/situation

If the child/youth is also enrolled in the Health Home program, a significant life event may also require a full CANS-NY to be completed. The CANS-NY is completed on a yearly cadence otherwise and may not coincide with the HCBS/LOC eligibility determination.

Participant Placed in an HCBS Restricted Setting

If a child/youth enrolled in the Children's Waiver is hospitalized or placed in an HCBS restricted setting, then the child/youth can remain in such setting for 90 days prior to having to be disenrolled from the Children's Waiver program. If the Waiver child/youth is also enrolled in the Health Home program while entering a restricted setting, the HHCM would "pend" the enrollment segment in the MAPP tracking system.

Follow the [Health Home Continuity of Care and Re-Engagement for Enrolled Health Home Members](#) policy.

Please also refer to Appendix G for guidance related to referring for HCBS while a child/youth is in a restricted setting, including a Residential Treatment Facility (RTF) or OMH State-operated Psychiatric Centers Serving Children (State PC).

HHCMs should also refer to the [HH Care Management Activities and Billing Protocols for Managing Newly Referred Individuals from Excluding Settings](#).

Capacity Management

Capacity Management is the process by which New York State manages the allowable number of enrolled participants and available slots for the 1915(c) Children's Waiver. Slot capacity is tracked by Target Population and by Region. Slot capacity is monitored to ensure that all regions have equitable access to the Children's Waiver. Should Capacity Management become concerned about Waiver enrollment reaching a threshold, then a waitlist might occur and limits by Target Population and Region will be set.

Capacity Management Process

The NYS DOH Capacity Management Team receives information from the Uniform Assessment System (UAS) daily reporting all completed HCBS/LOC Eligibility Determinations. This report allows the DOH Capacity Management Team to begin the process to place the K-codes on the participant's Medicaid file to notify HCBS providers and Medicaid Managed Care Plans that the child/youth is eligible and enrolled within the Waiver. The Capacity Management Team will notify the HHCM/C-YES assessor of any newly assessed (*initial assessment only*) **and** eligible child/youth of their slot availability within one business day of the completed, signed/finalized assessment outcome. The HHCM/C-YES assessor will receive a Health Commerce System (HCS) Secure File Transfer (SFT) email with a subject line "Slot Availability" indicating if the child/youth has secured a slot prior to HCBS being provided or if the child/youth is on a waitlist. The HHCM/C-YES should not send Notice of Decisions or send HCBS referrals to providers until verifying the new member slot availability.

It is necessary for HHCM/C-YES to also notify DOH Capacity Management Team when a participant is being disenrolled from the Waiver so the K-code can be removed from the participant's Medicaid file.

There are specific requirements about how and when communication is required by HHCM/C-YES to Capacity Management, which are located in the [Children's Waiver Communication to/from NYS Capacity Management Requirements](#) and the [Capacity Management and RR/E K-Codes Webinar](#).

Capacity Tracker/Waitlist

All HCBS Providers are required to complete the Children's Services Capacity Tracker survey every three weeks. Due dates for the survey are on Fridays at 11:59pm. The Children's Service Capacity Tracker is located within the Incident Reporting and Management System (IRAMS) system and is a requirement for compliance. In addition

to the survey, providers are required to maintain an ongoing waitlist within the system. This Capacity Tracker is distinct from the DOH Capacity Management Process outlined in the previous section.

For general guidance and instruction on the Children's Services Capacity Tracker System, please reference the [User Guide](#), [FAQ](#), and [webinars](#).

HCBS DISENROLLMENT

Overview

The HHCM/C-YES and HCBS providers maintain a responsibility for carrying out the discharge planning for the child/youth being disenrolled from the Children's Waiver and/or discharged from HCBS.

The situations under which children/youth may be disenrolled from the Children's Waiver and/or discharged from HCBS include:

1. Child/youth no longer meets admission criteria and/or meets criteria for another, more appropriate service, either more or less intensive.

2. Child/youth or parent/guardian withdraws consent for treatment.

3. Child/youth is not participating in the POC development and/or utilizing referred services.

4. Child/youth's needs have changed, and current services are not meeting those needs.

5. Child/youth's goals would be better served with an alternate service and/or service level.

6. Child/youth's POC goals have been met.

7. Child/youth's support system is in agreement with the aftercare service plan.

Additional information can be located in the [HCBS Waiver Disenrollment and Discharge Policy](#) and Appendix H of this Manual.

Disenrollment Process

Once determined that disenrollment is appropriate and/or necessary, the HHCM/C-YES will issue the child/youth/family a [Notice of Decision \(NOD\) for Discontinuance](#) explaining the reason for the disenrollment from the Children's Waiver. This notice should be sent within 1-2 business days of the decision made by the HHCM/C-YES to the family the lead HH, HCBS provider, and other care team members. Prior to sending the NOD, the HHCM/C-YES must discuss options with the child/youth/family, if they are no longer found eligible for HCBS, including their option to request a Fair Hearing, following the process as outlined in the [HCBS Notice of Decision for Discontinuance](#) and [HCBS Waiver Disenrollment and Discharge policy](#).

The HHCM/C-YES will also need to complete the Fair Hearing / State Review NOD within the child/youth's HCBS/LOC Eligibility Determination in the UAS to indicate the change in status.

The HHCM/C-YES must give notice to the HCBS providers, Medicaid Managed Care Plans, and other involved providers of the disenrollment/discharge of a participant.

The HHCM/C-YES must also communicate any discharge and/or disenrollment to DOH Capacity Management in a timely manner and provide the date of discharge or disenrollment, reason for discharge or disenrollment, name, date of birth, CIN, and Target Population. In instances of disenrollment, Capacity Management will remove the R/RE K-codes from the file (see Appendix K for a list of K-codes).

In addition to communication with Capacity Management, the HHCM/C-YES must also communicate the change in status with all involved interdisciplinary team members, provider(s), and MMCP, as appropriate.

Additional Information can be found in

The [HCBS Waiver Disenrollment and Discharge Policy](#).

Discharge from HCBS Process

In some cases, a child/youth may be discharged from an individual HCBS that no longer meets the child/youth's goals, but the child/youth may remain in receipt of additional needed HCBS and enrollment within the Waiver. In all instances of individual service discharge, whether accompanied by disenrollment from the Children's Waiver or continuation of alternative HCBS, both the HHCM/C-YES and HCBS provider(s) will need to execute and document the discharge planning process in the Case Record.

CARE MANAGEMENT AND MONITORING ACCESS TO CARE FOR HCBS

Care Management

Children and youth who are enrolled in the Children's Waiver, are HCBS/LOC eligible, and are receiving HCBS are required to receive care management. This requirement may be met in one of the following three ways:

- HH comprehensive care management: Children/youth eligible for HCBS are eligible for HH services, including comprehensive care management; care coordination and health promotion; comprehensive transitional care; enrollee and family support; and referral to community and social supports. HH comprehensive care management ensures a holistic assessment, through the CANS-NY and comprehensive assessments, of the child/youth's behavioral health, medical, community and natural supports as identified through a person-centered Plan of Care (POC) by the child/family.
- C-YES: If a child/youth and their family do not want HH care management (which is an optional benefit), they can opt-out of HH and receive HCBS care management from C-YES. C-YES will develop a HCBS POC using information from the HCBS/LOC Eligibility Determination, and a person-centered discussion that identifies personal goals and how specific HCBS may support the child in achieving those goals. C-YES will maintain the POC for children who opt of HH and are not enrolled in a Medicaid Managed Care Plan.
- MMCP: For children/youth who opt-out of HH and are enrolled with a MMCP, once C-YES establishes HCBS/LOC eligibility and the HCBS POC, the MMCP updates the POC annually through a person-centered planning process. C-YES conducts the HCBS/LOC Eligibility Determination annually for children/youth who are managed by the MMCP.

Care management is required for all participants receiving HCBS. The HCBS referred and provided cannot duplicate or replace existing and required care management services through HHCM/C-YES. HCBS providers must communicate with HHCM/C-YES regarding any additional care management needs the participant/family may have; it is then the HHCM/C-YES's responsibility to coordinate such related services.

Monitoring Access to Care

The State must ensure children/youth participating in the Children's Waiver are able to access and receive HCBS identified in the POC. The MMCP will monitor access to care for all enrolled children/youth in receipt of HCBS. The HH will monitor access to care for children and youth in receipt of HCBS who are enrolled in the HH and are not enrolled in an MMCP. C-YES will monitor access to care for children/youth in receipt of HCBS who opt out of HH and are not enrolled in an MMCP.

Monitoring access to care means that there is contact with the child/youth and family to ensure that they are receiving the HCBS indicated in the POC **within 45 days of the POC being signed** by the child/youth and the parent/guardian/legally authorized representative and have contact with the HCBS providers to ensure child/youth and family are attending the appointment and working toward established identified service goals.

Contact with the family may be by phone or other regular communication methods (unless otherwise outlined) and must occur at least once per quarter for C-YES and the MMCP and once per month for HHCMs. This verification can be combined with a regularly scheduled meeting or care management contact with the child/youth and family. HHCM/C-YES should document this contact in a case note. The monitoring access to care requirement does not change the high-medium billable standard for HHs. Alternatively, MMCPs can combine monitoring of access to care with the plan's service verification activity.

In-person meetings between the HHCM and the child/family are required based upon CANS-NY acuity or if the child/youth has Medicaid Family of One budgeting and is not receiving a monthly HCBS. In-person meetings must have a purpose and an outcome; meetings for social and recreational purposes are not appropriate.

Contact by the care management entity with HCBS providers must occur to ensure that appointment times and scheduling accommodates the family's schedule and ability to attend. Additionally, this contact occurs to verify that the service(s) is meeting the identified need and progressing towards established identified goals.

The HCBS provider(s) need to be an active member in the family's care team and person-centered POC development, monitoring, and planning. HCBS providers should attend meetings that discuss the POC, communicate with care managers regarding the child/youth's progress toward goals and/or any changes in status/significant life events, and be aware of care management requirements to facilitate an effective conversation with the child/youth.

PERSON-CENTERED PLAN OF CARE

Plan of Care (POC) Development

To develop a POC, the HHCM/C-YES must meet with the child/youth and their family and their identified care team to discuss the strengths and needs of the child/youth, using [person-centered planning guidelines/principles](#). The person-centered service planning process guides the delivery of services and supports towards achieving outcomes in areas of the individual's life that are most important to them (e.g., health, relationships, work, and home, etc.). HHCMs/C-YES and MMCPs are responsible for ensuring that the POC is developed and services are authorized in accordance with the POC. The PCSP process and POC must reflect the person's choices, preferences, and goals, and support his or her inclusion in the community.

The child/youth and their family/caregiver will lead the development of the POC, alongside the HHCM/C-YES and involved care team members. The POC development is based upon the assessment of needs which is determined through interaction with the child/youth, their family, the child/youth's representative (if applicable), and identified supports as well as through the multi-disciplinary team meeting/information, CANS-NY (for HH), HH Comprehensive Assessment, and HCBS/LOC Eligibility Determination. The POC involves collaboration between the HHCM/C-YES, the child/youth, the family/caregiver, family-identified supports, providers, other child-serving systems, and the MMCP (if enrolled).

The HHCM/C-YES will recommend services that can support the child/youth in reaching their defined goals and addressing identified needs. Each HCBS that the child/youth receive must be listed in their POC with a defined goal. HCBS providers must refer to the POC during service delivery to ensure that the services provided are in alignment with the POC. HCBS providers will also play a role in providing information to care managers regarding progress toward goals that will be used in updating the POC.

The POC will change and evolve over time as the child/youth meets their goals or there is a need for new services/supports. The POC is a fluid document that can be developed incrementally and may be updated at any time. At a minimum, the POC must be reviewed annually. The POC must also be reviewed any time the child/youth, and/or parent/guardian requests a review, and/or any time a significant life event occurs. The POC must be reviewed during the HCBS/LOC Eligibility determination reassessment.

The POC must be signed by the child/youth, if age appropriate (i.e., able to understand and contribute to their own POC) and/or the parent, guardian, or legally authorized

representative. All involved providers must be given an opportunity to contribute to the POC and, with informed consent of the child/parent/guardian/legally authorized representative, sign the POC when it is developed. Services must be provided within 45 days of POC approval (i.e., the date it is signed by the child/youth/parent/guardian).

POCs must be developed following the [NYS Person-Centered Planning Guidelines](#) and the [Health Home Plan of Care Policy](#).

Development of the POC and Referrals for HCBS

At the time of the initial development of the POC, the POC must identify the need(s) of the child/family, the chosen HCBS, and goal/outcome to be attained. The POC must be reviewed with the child/family, signed by the child/family, and copies given to the child/family and, with informed consent, to the involved multi-disciplinary team providers upon request if appropriate. HCBS providers should have a role in POC updates and changes to the POC. To obtain and document consent for the HCBS provider to communicate with care team members, HCBS providers must have their own consent form and related policy and cannot utilize the [HH 5201 form](#).

When adding identified needs and services to a POC (initial and/or updated), it is not necessary to immediately identify the specific providers; providers should be specified once it is assured the HCBS provider identified and chosen has availability to accept the referral. Additionally, forms have been developed, as indicated in this Manual, to facilitate updating and sharing the POC. This process will also ensure that the HHCM/C-YES are compliant with the child/family-specific Protected Health Information (PHI) requests regarding the sharing of the POC with various providers. HCBS providers must also follow requirements to protect PHI.

HCBS Service Plan

Once a HCBS provider receives a referral from a care manager, the HCBS provider will meet with the child/youth and family/caregiver to identify how the referred services will help to address identified needs. Based on the determination of needs, the HCBS provider is responsible for documenting the approach for service provision on an HCBS Service Plan for the services they expect to provide. The purpose of the HCBS Service Plan is to outline the service(s) that will/is provided with corresponding goals and objectives that describes the need for the service(s) and the anticipated benefit to the child/youth and family. The HCBS Service Plan determines the focus of the particular service(s), while also documenting the scope, duration, and frequency to which each service will be provided. An HCBS Service Plan is required to outline each of the services the HCBS provider is providing to the child/youth. If the child/youth is referred

to more than one HCBS provider, then each HCBS provider will have their own Service Plan for the services they will provide to the child/youth. The HCBS provider is required to communicate the scope, duration, and frequency of the service to the HHCM/C-YES and have regular contact regarding the service delivery and the service plan progress.

Components of a HCBS Service Plan

As with any Service Plan, it is expected that the plan will be developed within 30 days of the first in-person appointment with the child/youth and family/caregiver. The necessary components of the HCBS Service Plan should, at a minimum, include the following:

- a) Child's Name
- b) Child's home address and phone number
- c) Date of Birth
- d) CIN (Medicaid #)
- e) Managed Care Organization (if applicable) and Member ID
- f) Lead HH or C-YES
- g) HH CMA or C-YES
- h) HHCM or C-YES staff, including their contact information
- i) HCBS Provider: The name of the agency delivering services as well as contact information for the agency/provider
- j) Service Plan Development Date
- k) Goals and Objectives of the service(s)
- l) *Scope*: The service components and interventions being provided and utilized to address the identified needs of the child
- m) *Duration*: Describes how long the service will be delivered to the child and/or family. The duration of the service should correspond to the abilities of the child/family and be reflective of the billing unit identified by service.
- n) *Frequency*: Outlines how often the service will be offered to the child and/or family. Services may be delivered on a weekly, biweekly or monthly basis, according to the needs of the child and family.

Note: The duration of a service should not exceed six months at a time. This timeframe provides enough time for the HCBS provider to evaluate if the service(s) is meeting the child/youth's needs and whether the service(s) should be continued or discontinued.

Expectations for the Development of a HCBS Service Plan

The HCBS Service Plan should begin with the service(s) referred to an HCBS provider based upon the needs identified by the HHCM/C-YES. The HCBS Service Plan should continue the care manager's discussion with the child/youth and family/caregiver while ensuring their involvement in the development of the Service Plan and that the goals outlined by the child/youth and family/caregiver are captured in the plan. The

development of this plan should begin during the first meeting with the child/youth and family/caregiver as the goals are discussed. The HCBS Service Plan must be completed within 30 days of the first in-person appointment with the child/youth and family/caregiver. The duration and frequency of service delivery should not be dependent upon the availability of the provider, but rather, the availability and needs of the child/youth. The frequency of services should be in relation to other appointments or commitments the child/youth may have, including but not limited to any educational or vocational placement, medical or behavioral health therapies, community activities, etc. and not be delivered beyond "typical" hours available when these things are considered in addition to the child/youth's age, attention span, and development. HCBS cannot be provided during school/educational hours. A plan, including the types of interventions provided and the goals to be achieved, must be developed that is reflective of the developmental and physical needs of the child/youth.

The HCBS Service Plan should be monitored regularly , every month when services are delivered. If there is a significant change in the child/youth's health, hospitalization, functioning, living situation, incarceration, or other significant life event, the HCBS Service Plan must be reevaluated to determine whether the goals remain appropriate. The HCBS Service Plan may be modified at the request of the child/youth and family/caregiver at any time. Whenever a modification is made to the HCBS Service Plan, it must be reviewed in total with the child/youth and family/caregiver and appropriate signatures obtained, including the child/youth (if appropriate, and if not, it should be specified that the child is unable to provide a signature), the parent/caregiver of the child/youth and the signature of the HCBS provider. The HCBS provider must communicate with the HHCM/C-YES regarding any changes, so it can be determined if there is a change needed to the child/youth's POC as well as the potential for other services needed.

Note: Based on the 1915(c) Waiver amendment from April 2022, "Caregiver Family Supports and Services" (CFSS) was combined with "Community Self-Advocacy Training and Supports" (CSATS) into the consolidated service "Caregiver/Family Advocacy and Support Services." If a child had separate service plans for CFSS and CSTAS, these separate plans must be combined into one plan under the new service title. Please also note that when appropriate, a Service Plan may include all HCBS that a child/youth receives from an agency on one singular Service Plan.

Plan of Care Workflow

DOH issued the HCBS POC Workflow Policy and the required use of related forms to facilitate information sharing between the HHCM/C-YES, HCBS providers, and MMCPs.

Please refer to the [HCBS POC Workflow Policy](#) for the complete HCBS POC Workflow process.

PARTICIPANTS RIGHTS AND PROTECTIONS

Overview

In compliance with CMS and the 1915(c) Children's Waiver, participants must be informed of their rights and protections regarding their options to receive care, how to report a complaint and/or grievance, how to report abuse or suspected abuse, and when and how to request a Fair Hearing. Documentation indicating that this information has been provided must be included in the child/youth's case file maintained by the designated HCBS provider agency.

HHCMs and C-YES care managers must also adhere to guidance regarding protocols and reporting requirements intended to ensure the safety and well-being of Waiver participants.

Freedom of Choice

Eligible individuals must be informed of feasible alternatives for care and given the choice of either institutional or Home and Community-Based Services. During an in-person meeting, the HHCM/C-YES will provide information and discuss Freedom of Choice. The individual's parents/guardians/legally authorized represented must sign the [Freedom of Choice form](#) indicating their decisions and whether to participate in the HCBS 1915(c) Children's Waiver. This form must be witnessed and dated and kept as part of the member's HH/C-YES' file with a copy provided to the member upon request.

Care managers are responsible for explaining the participant's options and reviewing the Freedom of Choice form. With this form, the participant will indicate their decision for the following choices:

- Choice between HCBS and an institution (such as a hospital, ICF-IDD, or nursing home)
- Choice to receive care coordination through HH or C-YES; if choosing HH, the participant may also choose their CMA/care manager
- Choice of service providers

Although care managers are responsible for providing information regarding [Freedom of Choice and the Participant: Rights and Responsibilities Fact Sheet](#), HCBS providers should understand and honor the family's right to the choice of services and document that those choices were provided.

Incident Reporting

Care managers and HCBS providers must follow their agency processes for managing and recording *reportable incidents*, which include the following:

1. Allegation of abuse, including
 - Physical abuse
 - Psychological abuse
 - Sexual abuse/sexual contact
 - Neglect
 - Misappropriation of member funds
2. Suicide attempt
3. Death
4. Crime Level 1

Additional Information can be found in

The [Children's Waiver Participant: Rights and Responsibilities Fact Sheet](#).

5. Missing person
6. Violation of Protected Health Information (PHI)
7. Exploitation
8. The use of restrictive interventions, including restraints and seclusion

DOH requires that all complaints/grievances and critical incidents are timely documented within the Incident Reporting and Management System (IRAMS). HCBS providers must have procedures in place to ensure the timely review and resolution of member's complaints and grievances, and they are responsible for creating a process and informing the member of timeframes for addressing verbal or written complaints or grievances. This process must include contacting and updating the member within 72 hours of receiving the complaint or grievance. Response and resolution of the complaint or grievance process cannot exceed 45 calendar days from the receipt of the complaint or grievance. Documentation of the resolution must be in the member's file.

For further information, refer to the [IRAMS User Guide](#).

Care managers should refer to [Health Home Monitoring: Reportable Incidents Policies and Procedures](#), and HCBS providers should refer to [HCBS Provider Reportable Incidents Policies and Procedures](#).

Grievances and Complaints

Care managers and HCBS providers must follow their agency processes for managing and reporting grievances and complaints. Grievances and complaints are external to, but not in lieu of, the existing right to request a Fair Hearing. Children's Waiver participants should be informed, by their care manager, of the process for submitting a grievance or complaint related to their HCBS, care coordination, or participation in the Children's Waiver.

DOH's process for grievances and complaints is not intended to replace the Medicaid Fair Hearing process and therefore, members should be made aware that filing a grievance or making a complaint is not a prerequisite or substitute for a Medicaid Fair Hearing. DOH requires that all complaints/grievances and critical incidents are timely documented within the Incident Reporting and Management System (IRAMS).

For further information, refer to the [IRAMS User Guide](#).

MMCPs should refer to requirements for addressing and reporting grievances and complaints as outlined in the [Model Contracts](#) and [1915\(c\)](#).

Health Homes should refer to the [Health Home Grievances and Complaints Policy](#), and HCBS Providers should refer to the [HCBS Provider Grievances and Complaints Policy](#).

Conflict Free Case Management

Per federal regulation §441.301(c)(1)(vi), states are required to separate case management (including the development of person-centered plans) from service delivery functions for services delivered under 1915(c) waivers. Care managers must implement conflict-free case management principles. A "conflict of interest" is defined as a "real or seeming incompatibility between one's private interests and one's public or fiduciary duties." When the same entity is both assisting an individual to gain access to services and providing services to that individual, the role of the care manager has potential to be conflicted. Further, for HHCMs who are also employed by an HCBS provider, that HHCM cannot provide HCBS to children/youth who are also on the HHCM's case load.

Additional Information can be found in

The [Conflict Free Case Management Policy](#).

Note: To maintain the enrollee's autonomy and Freedom of Choice, it is not allowable for a HHCM or HCBS Provider to be related by blood or marriage to the served child/youth. Further, an individual residing in the same residence as the HCBS-enrolled child/youth or in a relationship with someone residing in the same residence, would not be an appropriate HHCM or HCBS provider. It is up to the agency to determine if a conflict of interest is present in a potential staffing relationship beyond the specifics provided above, and whether the family believes there is an opportunity for Freedom of Choice. Subsequently, it is not appropriate and is a conflict to request that the child/youth/family/caregiver find and or obtain their own provider to then be employed by an HCBS provider.

Quality Monitoring and Oversight

HCBS providers are responsible to develop policies, procedures, and processes that align with the requirements to deliver HCBS. HCBS providers are required to ensure all staff/employees/providers working for the designated agency are properly trained to all HCBS requirements and monitored for compliance with the requirements outlined in the [Background Check Requirements for HCBS Providers policy](#). HCBS providers should have a process in place to monitor and regularly audit cases and the delivery of services.

Annual Children's Waiver Case Review and Audit

On an annual basis, the NYS DOH will conduct a case review and audit of the previous waiver year's (April 1st through March 30th) services and providers, inclusive of HCBS providers, Health Homes, Health Home care managers, and C-YES policies, records, reporting, claims/billing, and other HCBS requirements. This information is required to be reported to NYS DOH as part of the waiver annual case review and audit to meet performance measures within the Children's Waiver and reported to CMS.

HHs, HH CMAs, C-YES, and HCBS providers must comply with all requests for records and files, as well as agency's/organization's practices as requested by NYS DOH or their designee. Agencies/organizations can be de-designated for care management services or HCBS if failing to meet these requirements.

BILLING AND CODING FOR HCBS

Overview

This section outlines general claiming requirements necessary to ensure proper claim submission for HCB services. This information was previously located in the separate *New York State Children's Health and Behavioral Health Medicaid System Transformation: Billing and Coding Manual* and has been integrated into this Manual instead, with general information in the "Billing and Coding for HCBS Services" section and service-specific details, such as rate codes, within the "Service Definitions" section.

The content included within applies to services covered by Medicaid Managed Care (MMC) and the Medicaid fee-for-service (FFS) delivery system. The billing guidance in this document does not supersede applicable regulatory requirements or procedures for admission to a program, record keeping, service documentation, initial and on-going treatment planning and reviews, etc. Contents of this Manual are subject to change.

Fundamental Requirements

Provider Designation to Deliver Services

Providers are required to receive a designation from NYS to provide and be reimbursed for Children's HCBS. For more information qualifications required for provider designation, refer to "Provider Requirements" section of this Manual.

Services that Do Not Require State Designation

The following services do not require State designation; these will be coordinated between the Care Management agency/C-YES, LDSS/MMCP, and DOH.

- Adaptive and Assistive Technology (AT)
- Environmental Modifications (EMods)
- Vehicle Modifications (VMods)
- Non-Medical Transportation

Medicaid-Enrolled Provider

As referenced earlier in this document, all providers eligible to enroll in Medicaid are required to enroll in Medicaid to be paid for delivering a Medicaid service. Information on how to become a Medicaid provider is available on the [eMedNY website](#).

For additional information specific to Medicaid provider enrollment for children/youth services, refer to the [MCTAC CTAC training](#) and the DOH memo on [Medicaid Provider Enrollment for Individual Practitioners and Designated Agencies](#).

Medicaid Managed Care Plan Contracting

To be paid for services delivered to a child/youth enrolled in a Medicaid Managed Care Plan, a provider must be contracted and credentialed with that MMCP for the service rendered (i.e., in the MMCP's network).

A MMCP has discretion to deny a claim from an out of network provider:

- Exception: For any of the newly carved-in services, if a provider is delivering a service to the enrollee prior to the implementation date and does not contract with the MMCP, the MMCP must allow a provider to continue to treat an enrollee on an out of network basis for up to 24 months following the implementation date.
- Single Case Agreements (SCA) may be executed between a MMCP and a provider when an out of network provider has been approved by a MMCP to deliver specific services to a specific MMCP enrollee. MMCPs must execute SCAs with non-participating providers to meet clinical needs of children/youth when in-network services are not available. The MMCP must pay at least the NYS government rates for 24 months from the service implementation date.

MMCPs are held to specific network requirements for services described in this Manual. NYS monitors MMCP contracting regularly to ensure network requirements are met.

RATES

Government Rates

NYS law requires that MMCPs pay government rates (otherwise known as Medicaid fee-for-service rates) for certain services, including Children's HCBS, administered by a MMCP.

MMCPs will be required to pay government rates until otherwise notified.

Productivity Adjustment

HCBS rates are subject to change based on factors such as budget adjustments, Waiver amendments, Federal regulation, and other similar external events. Any temporary rate adjustments for the budget year will be reflected in the HCBS rate chart available on the [DOH website](#).

Regions

Regions are assigned to providers based upon the geographic location of the provider's headquarters, and are defined by DOH as follows:

- *Downstate*: 5 boroughs of New York City, counties of Nassau, Suffolk, Westchester, Rockland, Putnam, Orange, Dutchess, Sullivan and Ulster
- *Upstate*: Rest of State

CLAIMS

General Claim Requirements¹

Electronic claims will be submitted using the 837i claim form to both Medicaid FFS and MMCPs. Paper claims (UB-04) and web-based claiming will also be accepted by MMCPs. For Medicaid Managed Care billing for EMods, VMods, and AT, please refer to applicable guidance in this Manual.

Each service has a unique rate code. If a child/youth receives multiple services in the same day with the same Current Procedural Terminology (CPT) code, but separate rate codes and modifiers, all services would be payable.

Enrollment Status

Before delivering services to a child/youth, providers are responsible for checking the Electronic Provider Assisted Claim Entry System (ePaces)² to verify the child/youth's:

- Medicaid enrollment status
- HCBS eligibility status – both Level of Care (LOC) and active, correct k-code (before delivering HCBS)
- MMCP enrollment status

Claims will not be paid if a claim is submitted for a child/youth who is not enrolled with Medicaid, a child/youth not eligible for HCBS, or if the claim was submitted to an incorrect MMCP.

Medicaid Fee-For-Service Claiming (eMedNY)

Claims for services delivered to a child/youth in receipt of fee-for-service Medicaid are submitted by providers to eMedNY. See the [eMedNY website](#) for training on use of the eMedNY system. Claim submissions need to adhere to the 90-day timely filing rules for Medicaid FFS, unless the claim is delayed due to circumstances outside of the provider's control—for example, attempts to recover from a third-party insurer or legal

¹ NYS will be reviewing claim and encounter data periodically and annually, or upon information that there has been fraud or abuse, to determine if inappropriate HCBS combinations were provided/allowed. In instances where such combinations are discovered, NYS will make the appropriate recoveries and referrals for judicial action.

² ePaces is a web-based application which will allow Providers to create/submit claims and other transactions in HIPAA format.

proceedings against a responsible third-party. See NYS Medicaid timely billing guidance [here](#).

Medicaid Managed Care Plan Claiming

MMCPs and providers must adhere to the billing and coding rules in this Manual. The MMCP shall support both paper and electronic submission of claims for all claim types. The MMCP shall offer its providers an electronic payment option including a web-based claim submission system. MMCPs rely on CPT codes and modifiers when processing claims. Therefore, all MMCPs will require claims to be submitted with the CPT code and modifier (if applicable), in addition to the NYS assigned rate code.

Providers will enter the rate code in the header of the claim as a value code. This is done in the value code field by first typing in "24" followed immediately with the appropriate four-digit rate code. This is the standard mechanism historically and currently used in Medicaid FFS billing.³

Billing requirements depend on the type of service provided; however, every claim submitted will require at least the following:

- Use of the 837i (electronic) or UB-04 (paper) claim format
- Medicaid fee-for-service rate code
- Valid CPT code(s)
- CPT code modifiers (as needed)
- Units of service
- Revenue codes

Sample institutional claim form can be found through [MCTAC/CTAC](#).

MMCPs will not pay claims if submitted without the applicable rate code, CPT code, and modifiers. If an individual service has multiple modifiers listed, they must all be included on the claim submission. If an MMCP receives an HCBS claim for a child whose enrollment in the Children's Waiver cannot be verified by confirming a K1 Recipient Restriction/Exemption (RR/E) code on the child's record, and/or if the MMCP has not received an HCBS Authorization and Care Manager Notification Form for the billed service(s) provided beyond the initial 24 hours/60 days/96 units, the MMCP should deny the claim for lack of verification of Children's Waiver eligibility, enrollment, and approved service. The MMCP may also deny the claim if the units billed are not supported by the frequency, scope, and duration documented on the HCBS [Authorization and Care Manager Notification Form](#).

³ Attention MMCPs: This field serves a dual purpose and is already used by MMCPs to report the weight of a low birth weight baby.

Providers must adhere to timely filing guidelines as outlined in their contract with the MMCP. When a clean claim is received by the MMCP, the Plan must adjudicate per prompt pay regulations.

If a provider does not have a contract or a Single Case Agreement in place with the MMCP, the claim can be denied.

Services Included in or Excluded from Capitation Payments to Medicaid Managed Care Plans

The MMCP capitation payment will not include Children's HCBS and MMCPs will not be at-risk for Children's HCBS until at least September 30th, 2023. DOH will confirm this date in writing. MMCPs will be reimbursed on FFS basis outside the capitation rate by submitting claims for Children's HCBS to NYS under supplemental rate codes.

All non-risk payment claims that have a valid delay reason code must be submitted to eMedNY within two years from the date of service. Please refer to [eMedNY](#) for further information regarding non-risk billing guidance.

Non-risk payment claims must include the same fields as in all other claims (i.e., rate code, procedure code, modifier(s) as applicable, units of service, revenue codes). The rate code/CPT code/modifier code combinations for the services described in this document are shown within each "Service Billing Details" subheader in the Service Definitions section.

Third-Party Health Insurance Denials

It is the provider's responsibility to determine the type of coverage (Medicare, Medicaid, or private insurance) that the member is eligible to receive. Medicaid is the payor of last resort and all Medicare and third-party coverage must be exhausted before payment for HCBS by Medicaid.

Acceptable documentation of attempts to secure third party reimbursement as required under [18 NYCRR §540.6](#) includes documentation of a rejection by third party insurance for a date of service within the previous 12 months of the date of service being billed, or since a change in third party coverage, whichever is later.

There are exceptions to this requirement for 29-I Health Facilities delivering HCBS to children/youth in foster care. Refer to the [29-I Billing Manual](#) for additional details.

Services Delivered by Multiple Staff Members

If two practitioners are required to deliver a service to a child/youth and family members/resources on the same date and at the same time, the provider must delineate what service and what goals each practitioner is addressing directly with the child/youth and on behalf of the child/youth in the child/youth's progress notes. The need for two practitioners should reflect the needs of the child/youth and/or family/caregiver and be aligned with the goals outlined in the POC and HCBS Service

Plan. The claim should reflect the time spent for each practitioner in a single claim. Services and staffing should be streamlined whenever possible. No more than two practitioners can provide HCBS to the child/youth and family members/resources on the same date and at the same time.

Example: Practitioner (A) meets with the child/youth directly to deliver Caregiver/Family Advocacy and Support Services from 10:00 am to 10:30 am and Practitioner (B) meets with a family member/resource to deliver Caregiver/Family Advocacy and Support Services addressing a need on the behalf of the child/youth from 10:00 am to 10:30 am. The combined claim would reflect the 60-minute combined duration of the service.

Children's HCBS participants cannot receive the same HCBS from multiple designated provider agencies (e.g., participant cannot receive Planned Respite from both Provider Agency (A) and Provider Agency (B). If extenuating circumstances necessitate the provision of the same HCBS from different providers, the HHCM/C-YES must provide documented justification for these scenarios and receive approval from the State.

Multiple Services Provided on the Same Date to the Same Child/Youth

In some cases, a child/youth can receive multiple HCB services on the same day. This can include services provided by separate providers (e.g., planned respite and Supported Employment). If these services are allowed per the service combination grid in this Manual, they would both be reimbursable when billed using the appropriate rate code and CPT code.

Services Provided During School/Day Time

HCBS cannot be duplicative or delivered at the same time as services otherwise available to the individual through a local educational agency for educational services in grades K - 12 under the Individuals with Disabilities Education Act (IDEA) or Vocational Rehabilitation under the Rehabilitation Act of 1973.

The schedule for HCBS delivery for children/youth who attend K-12 school in-person must be outside of regular school hours. For students who are home schooled or receiving virtual instruction, HCBS can be delivered during traditional school hours, but the services must be outside the scheduled time for educational instruction provided to the child.

Support for adult education outside of K-12 education may be provided under the HCBS waiver. Technical schools, colleges, and other adult education settings are approvable HCBS settings because adult education and adult education settings are not addressed/prohibited under the IDEA.

Please refer [to HCBS Versus State Plan Services Delivered During School/Day Time](#) for more information.

Services Provided While in Transit

Services that are delivered in transit are allowable and may be billed within the daily limits of the service.

For example, a Caregiver/Family Advocacy and Support Services worker escorts a family to a destination where the family will implement a strategy supported by the Caregiver/Family Advocacy and Support Services worker; while in route, the Caregiver/Family Advocacy and Support Services worker talks through the plan to help prepare the family. The time spent in transit would be considered part of the billable service. Transportation is not reimbursable.

Out of State Services

Only providers located in New York State are eligible to become designated HCBS providers. Children/youth must be enrolled in New York State Medicaid to receive Children's HCBS, and the services must be provided in the state in which the Medicaid recipient is enrolled in Medicaid. As such, while an individual HCBS provider may reside in a neighboring state, the HCBS must be provided in New York State by an HCBS provider that is located in and designated in New York State.

Submitting Claims for Services When the Child/Youth Is Not Present

Services delivered on behalf of a child/youth to collateral contacts (family members, caregivers, and other stakeholders identified on the child/youth's plan of care) without the child/youth present are allowable and may be billed within the daily limits, if the service description includes interaction with collateral contacts.

Such services may include sharing techniques and information so the collateral can better respond to the needs of the child/youth, meetings with employers or prospective employers regarding the child/youth's needs, or education and training for family members/caregivers.

For example, a child/youth receives Day Habilitation services on Mondays and Wednesdays and is employed at a movie theatre on Tuesdays, Thursdays, and Fridays. The job coach has a 30-minute meeting with the supervisor at the movie theatre on a Monday to discuss new job responsibilities for the child/youth. The service provider may bill for Supported Employment services for the 30-minutes, even though the child/youth was not present when the service was delivered and even though the child/youth was receiving another service (Day Habilitation) at the time that Supported Employment was delivered on the child/youth's behalf, this is not considered double billing because the child/youth is receiving two separate services.

Submitting Claims for Non-Sequential Time for the Same Service, on the Same Day

If the same service is delivered to the same child/youth on the same day but at non-sequential times, the total time spent on the service must be submitted as a combined claim.

For example, from 10:00am to 10:15am, a job developer meets with a potential employer about hiring a child/youth receiving supported employment services. If, later in the same day, provider staff meet with the child/youth and their family from 1:15 pm to 1:45 pm to discuss the potential new job, the service provider would document the multiple services provided during the day and bill for a combined time of 45 minutes (3 units) at the individual fee.

Timed Units per Encounter of Service

Timed Units per Encounter of Service

Range of Minutes per In-Person Encounter	Billable Minutes	Billable Units (15 Minutes per Unit)
Under 8 minutes	1-7 minutes	Not billable
8-22 minutes	15 minutes	1 unit
23-37 minutes	30 minutes	2 units
38-52 minutes	45 minutes	3 units
53-67 minutes	60 minutes	4 units
68-82 minutes	75 minutes	5 units

Range of Minutes per In-Person Encounter	Billable Minutes	Billable Units (15 Minutes per Unit)
83-97 minutes	90 minutes	6 units
98-112 minutes	105 minutes	7 units
113-127 minutes	120 minutes	8 units

Submitting Claims for Daily Billed Services

Services that are billed on a daily basis should be submitted on separate claims.

Claims Coding

The Service Billing Details for each HCBS shows the rate code, CPT code, and modifier code combinations that are required under Medicaid Managed Care. Providers will use these coding combinations to indicate to the MMCP that the claim is for a children/youth's service and is to be paid at the government rate. The procedure and modifier code combinations must be adhered to by both provider and MMCP to ensure appropriate rate payment.

Claims Testing

MMCPs will reach out and offer billing/claim submission training to newly contracted Children's HCBS providers and Children's HCBS providers in active negotiation to contract. This will include testing claims submission and processing, and issuance of MMCP contact and support information to assist programs in claim submission.

Children's HCBS providers are expected to test the claims submission process with MMCPs for all delivered services prior to the service implementation date and upon executing a new contract.

Service Combinations

Only certain combinations of Children's HCBS and State Plan services are allowed by Medicaid within a child/youth's current treatment plan. Appendix M has a table showing the allowable service combinations.

When determining which service should be utilized, MMCPs, providers, families, and care managers should discuss which services best meet the individual needs of the child/youth.

Provider Assistance

MMCPs are required to develop and implement provider training and support programs for network providers. This training and support will allow network providers to gain the appropriate knowledge, skills, and expertise, and receive technical assistance to comply with the MMCPs' requirements. Training and technical assistance shall be provided to network providers on billing/claims submission, coding, data interface, documentation requirements, and UM requirements.

Network providers shall be informed in writing regarding the information requirements for UM decision making, procedure coding and submitting claims. MMCPs will provide technical assistance in other areas such as claim submission as indicated by provider performance identified through the quality management and provider profiling programs put in place by the MMCP. MMCPs will ensure providers receive prompt resolution to their inquiries.

WHERE TO SUBMIT QUESTIONS AND COMPLAINTS

If you have questions or complaints, please reach out to the following mailboxes:

- Regarding HCBS or the Children's Health and Behavioral Health System Transformation generally: BH.Transition@health.ny.gov
- Specific to Medicaid Managed Care and for any type of provider/service: Managedcarecomplaint@health.ny.gov
- Specific to a mental health provider/service: OMH-Managed-Care@omh.ny.gov
- Specific to a substance use disorder provider/service: PICM@oasas.ny.gov
- Specific to an OPWDD provider/service: Central.Operations@opwdd.ny.gov
- Specific to a Health Home provider/service: HHSC@health.ny.gov

SERVICE DEFINITIONS

Overview

As described in the introduction of this Manual, all HCBS have been approved by CMS through the 1915(c) Children's Waiver and 1115 MRT Waiver. There are currently 14 services available to children/youth that meet the diagnostic and functional criteria for HCBS and each service:

1. Community Habilitation
2. Day Habilitation
3. Caregiver/Family Advocacy and Support Services
4. Respite (*both Planned and Crisis*)
5. Prevocational Services
6. Supported Employment
7. Palliative Care – Expressive Therapy
8. Palliative Care – Massage Therapy
9. Palliative Care – Counseling and Support Services
10. Palliative Care – Pain and Symptom Management
11. Adaptive and Assistive Technology
12. Vehicle Modifications
13. Environmental Modifications
14. Non-Medical Transportation

Each service has unique requirements. Please review the following sections for more details on each service including Definition, Service Components, Modality, Setting, Certification/Provider Qualifications, Training Requirements, and Service Billing Details.

As a reminder, all services need to be properly documented in the participant's POC and HCBS Service Plan. Services and staffing should be streamlined whenever possible, with no more than two practitioners providing HCBS to the child/youth and family members/caregivers on the same date and at the same time. In addition, care management is required for all participants receiving HCBS. The HCBS referred and provided cannot duplicate or replace existing and required care management services through HH/C-YES. HCBS providers must communicate with HHCM/C-YES regarding any additional care management needs the participant/family may have; it is then the HHCM/C-YES's responsibility to coordinate such related services, as the HCBS provider cannot provide any HCB Services without the HHCM/C-YES knowledge, referral, and documented on the POC.

Community Habilitation

Definition

Community Habilitation covers in-person services and supports related to the child/youth's acquisition, maintenance, and enhancement of skills necessary to perform

Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and/or Health-Related Tasks delivered in the community (non-certified) settings.

Acquisition is described as the service available to a child/youth who is seeking greater independence by learning to perform the task for him or herself. There should be a reasonable expectation that the individual will acquire the skills necessary to perform that task within the authorization period.

Maintenance is described as the service available to prevent or slow regression in the child/youth's skill level and to prevent loss of skills necessary to accomplish the identified task.

Enhancement activities are provided to the child through training and demonstration to promote growth and independence with an already acquired skill level and to support the child/youth's goal outside of the training environment.

ADL, IADL, skill acquisition, maintenance, and enhancement are in-person services that are determined by the person-centered planning process and must be identified in the child/youth's POC on an individual or group basis. These identified services will be used to maximize personal independence and integration in the community, preserve functioning, and prevent the likelihood of future institutional placement. Skill acquisition, maintenance, and enhancement services are appropriate for children/youth who have the capacity to learn to live in the community, with or without support. Community Habilitation may be delivered in individual or group modality.

Service Components

ADL, IADL skill acquisition, maintenance, and enhancement is related to assistance with functional skills and may help a child/youth who has difficulties with these types of skills accomplish tasks related to, but not limited to:

- Self-care
- Life safety
- Medication and health management
- Communication skills
- Mobility
- Community transportation skills
- Community integration
- Appropriate social behaviors
- Problem solving
- Money management

Provider and Condition Requirements

ADL, IADL, skill acquisition, maintenance, and enhancement will be performed by a direct care worker, who shall include personal care aides, personal attendants, certified home health aides, direct service professionals who meet the licensure and certification

requirements under NYCRR Title 18, and/or providers approved through OPWDD to provide Community Habilitation.

ADL, IADL skill acquisition, maintenance, and enhancement must be provided under the following conditions:

- The need for skills training or maintenance activities has been assessed, determined, and authorized as part of the person-centered planning process
- Provider agencies of Community Habilitation must develop a Community Habilitation Service Plan to document the child/youth's goal(s)/outcome(s), health/safety needs required during the delivery of the service, and the necessary staff actions to assist the child/youth reach his/her Community Habilitation goal(s)/outcome(s), and health/safety needs; the activities are for the sole benefit of the child/youth and are only provided to the child receiving HCBS or to the family/caregiver in support of the child/youth
- The activities are designed to preserve or enhance independence or slow/reduce the loss of independence when the child/youth have a progressive medical condition; the activities provided are consistent with the child/youth's stated preferences and outcomes in the POC
- The activities provided are coordinated with the performance of ADLs, IADLs, and health-related tasks
- Training for skill acquisition, maintenance, and enhancement activities that involve the management of behaviors must use positive enforcement techniques
- The provider is authorized to perform these services for HCBS recipients and has met any required training, certification, and/or licensure requirements

Some specific ADL services available for training include, but are not limited to: bathing/personal hygiene; dressing; eating; mobility (ambulation and transferring); and toileting.

Some specific IADL services available for skills training include, but are not limited to: managing finances; assisting with transportation (as indicated in the POC); shopping for food, clothes, and other essentials; preparing meals; assisting with the use of the telephone and/or other communication devices; managing medications; light housekeeping; environmental maintenance such as maintaining safe egress; and laundry.

If the POC indicates that learning how to navigate travel from one location in the community to another is a goal for the child, this service will include the assistance provided by a direct care worker to accompany the child/youth while learning the skill. The in-person service time when a direct care worker is assisting or providing transportation to an individual may also be billed as part of the Community Habilitation service.

Health-related tasks are defined as specific tasks related to the needs of a child/youth, which can be delegated or assigned by licensed healthcare professionals under state law to be performed by a certified home health aide or a direct service professional.

Health-related tasks also include tasks that home health aides, or a direct service professional can perform under applicable exemptions from the [Nurse Practice Act](#).

Some specific health-related tasks available for assistance include but are not limited to: performing simple measurements and tests; assisting with the preparation of complex modified diets; assisting with a prescribed exercise program; pouring, administering, and recording medications; assisting with the use of medical equipment, supplies, and devices; assisting with special skin care; assisting with a dressing change; and assisting with ostomy care.

Modality

- Individual in-person service
- Group in-person service

Setting

These services can be delivered at any non-certified, community setting. Such a setting might include the child/youth's home, which may be owned or rented, and work setting.

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community-based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network. Family is broadly defined, and can include families created through birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

Please note that this service cannot be substituted for vocational rehabilitation services provided under the Rehabilitation Act of 1973 or other Children's HCBS. Approved settings do not include an OPWDD certified residence, congregate or institutional settings, a social day care or health care setting in which employees of the particular setting care for or oversee the child/youth. Foster Care children/youth meeting LOC may receive these services in a home or community-based setting where they reside that is not an institution. OCFS Licensed Institutions are defined in New York State Social Services Law section 427.2(f) as a facility established for the 24-hour care and maintenance of 13 or more children and operated by a childcare agency (Voluntary Foster Care Agency).

Only those services not reimbursable under the Community First Choice Option (CFCO) State Medicaid Plan will be reimbursable under this HCBS Waiver.

Children/youth living in certified settings may only receive this service on weekdays with a start time prior to 3 pm and are limited to a maximum of six hours of non-residential

services (or its equivalent) daily. For school-age children/youth, this service cannot be provided during the school day when a child/youth is participating or enrolled in a school program. Time spent receiving another Medicaid service cannot be counted toward the Community Habilitation billable service time. This service cannot be delivered nor billed while a child/youth is in an ineligible setting, such as in a hospital, ICF/IID, or skilled nursing facility. Community Habilitation services provided under this waiver cannot be duplicative or delivered at the same time as services otherwise available to a child/youth through a local educational agency including those services available under the Individuals with Disabilities Education Act (IDEA) or Rehabilitation Act of 1973.

Certification/Provider Qualifications

Provider Agency Qualifications

New York State Office for People with Developmental Disabilities (OPWDD) certified, not-for-profit habilitation provider agencies.

Practitioners must operate in agencies that have been designated through the NYS Children's Provider Designation Review Team. This requires that agencies have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners must adhere to all Medicaid requirements in this Manual and in other applicable provider manuals, regulations, and statutes
- Provider agencies must adhere to cultural competency guidelines
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served
- The provider agency must ensure that staff receive Mandated Reporting training prior to service delivery
- The provider agency must ensure that practitioners maintain the licensure necessary to provide services under their scope of practice under State law, if applicable
- The provider agency must ensure that any insurance required by the designating state agency is obtained and maintained
- The provider agency must ensure that any safety precautions needed to protect the child/youth population served are taken as necessary and required by the designating State agency

Additional information and application for Children's HCBS can be found on the [DOH website](#).

Individual Staff/Agency Qualifications

Providers must have appropriate license, certification, and/or approval in accordance with State requirements.

OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by DOH and the HHS Office of the Inspector General.

Direct support professionals must be employed by the designated agency and have completed the training stipulated in 14 NYCRR Part 633.8 and the Direct Support Professionals Core Competencies curriculum.

Additional information can be found in the [DSP Core Competencies section of the OPWDD website](#).

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Community Habilitation	<ul style="list-style-type: none"> • Mandated Reporter • Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • Prior to service delivery • Training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix E.

Service Billing Details

Rate Code Description

The below table shows the show the rate code, CPT code, and modifier code combinations that will be required under Medicaid Managed Care. Providers will use these coding combinations to indicate to the MMCP that the claim is for a children/youth's service and is to be paid at the government rate. The procedure and modifier code combinations must be adhered to by both provider and MMCP to ensure appropriate rate payment.

In acknowledgement of the need for checks against fraud and abuse, but to ensure a child/youth's access to services, service utilization in excess of the "soft" unit (i.e., annual, daily, dollar amount) limits must be based on medical necessity. Documentation of the medical necessity for extended durations must be kept on file in the child/youth's record. HCBS should be initially authorized for no more than six months at a time and based on each participant's unique needs. To exceed billing limits for children/youth enrolled in managed care, providers must contact the MMCP to receive guidance regarding the Plan's specific documentation requirements in these instances ; for children/youth enrolled in FFS, HCBS providers must maintain documentation from a licensed professional that outlines the need to exceed the service limit (e.g., copy of an assessment from a licensed professional; letter from a licensed professional that clearly describes the need for additional units of service, etc.).

In addition to requiring concurrent utilization review and authorization, the MMCP may conduct post-payment administrative reviews to ensure services were provided appropriately.

Community Habilitation					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Community HCBS Habilitation	8012	H2014	HA	15 minutes	24/day
Community HCBS Habilitation - Group of 2	8013	H2014	HA, UN	15 minutes	24/day
Community HCBS Habilitation – Group of 3	8014	H2014	HA, UP	15 minutes	24/day

Guidelines for Medical Necessity Criteria for Children, Adolescents, and Young Adults

The hours/ billing units are provided as guidance and may be exceeded with additional review. Factors to be considered regarding higher service levels include other available paid services. Consideration must also be made for natural supports and individual needs at the time of the request and included in the assessment and Plan of Care.

Age Range	Typical Approval Ranges	Admission and Criteria	Discharge Criteria
Children Ages 0 - 2	0 hours/ 0 units per week	<ul style="list-style-type: none"> Skill building typically met through parental support/ natural caregivers and use of services such as Early Intervention (EI) and educational/ school programs. Services necessary at this age typically provided by licensed practitioners including Occupational Therapy, Physical Therapy, and Speech Therapy 	<ul style="list-style-type: none"> Child/ youth no longer meets Level of Care (LOC) for Home and Community-based Services (HCBS); OR Child/ youth no longer wishes to receive the service or withdraws consent for the service; OR EI services are made available; OR Child/ youth has successfully met their specific goal outlined in their service plan and no

Age Range	Typical Approval Ranges	Admission and Criteria	Discharge Criteria
		<ul style="list-style-type: none"> • CH should be used as described and not in lieu of another, more appropriate service • CH will only be authorized when clear documentation exists of a lack of availability of EI services, EI Respite and/or other Respite services and natural supports (e.g., parent has a disability and the provision of CH supports the child and parent skill development or the family has significant stressors that negatively impact the ability to support the child) 	<p>longer needs this service; OR</p> <ul style="list-style-type: none"> • Child/ youth is no longer engaged in the service despite multiple attempts on the part of the provider to apply reasonable engagement strategies; OR • Child/ youth moves to a certified residential setting
Children Ages 3 - 9	0 to 3 hours per week/ 0 to 12 units per week	<ul style="list-style-type: none"> • Supports to facilitate community inclusion, relationship building, and adaptive/ social skill development, when not available through Preschool Supportive Health services, School Supportive Health services, or other Respite services. May include social skills groups, music or art therapy where the child is working to develop specific goals on their person-centered plan such as appropriate social interaction and mimicking others • CH should be used as described and not in lieu of another, more appropriate service • CH will only be authorized when clear documentation exists of 	<ul style="list-style-type: none"> • Child/ youth no longer meets LOC for HCBS; OR • Child/ youth no longer wishes to receive the service or withdraws consent for the service; OR • Child/ youth has successfully met their specific goal outlined in their service plan and no longer needs this service; OR • Child/ youth is no longer engaged in the service, despite multiple attempts on the part of the provider to apply reasonable engagement strategies; OR • Child/ youth moves to a certified residential setting

Age Range	Typical Approval Ranges	Admission and Criteria	Discharge Criteria
		<p>a lack of availability of Respite services and natural supports (e.g., parent has a disability and the provision of CH supports the child and parent skill development or the family has significant stressors that negatively impact the ability to support the child)</p> <ul style="list-style-type: none"> • Not allowed during school/ educational hours 	
Children Ages 10 - 13	0 to 10 hours per week/ 0 to 40 units per week	<ul style="list-style-type: none"> • Supports to facilitate community inclusion, relationship building, and adaptive/ social skill development • Average hours and need for CH typically increase over the years to support a growing level of developmental independence • Not allowed during school/ educational hours 	<ul style="list-style-type: none"> • Child/ youth no longer meets LOC for HCBS; OR • Child/ youth no longer wishes to receive the service or withdraws consent for the service; OR • Child/ youth has successfully met their specific goal outlined in their service plan and no longer needs this service; OR • Child/ youth is no longer engaged in the service, despite multiple attempts on the part of the provider to apply reasonable engagement strategies; OR • Child/ youth moves to a certified residential setting
Children Ages 14 - 17	0 to 15 hours per week/ 0 to 60 units per week	<ul style="list-style-type: none"> • Focus on transition activities including increased independence/ life skill building including prevocational type skills such as riding the bus, grocery shopping, using the library, 	<ul style="list-style-type: none"> • Child/ youth no longer meets LOC for HCBS; OR • Child/ youth no longer wishes to receive the service or withdraws consent for the service; OR

Age Range	Typical Approval Ranges	Admission and Criteria	Discharge Criteria
		<p>understanding health issues, personal appearance and hygiene</p> <ul style="list-style-type: none"> • Not allowed during school/ educational hours • If child/ youth graduates/ discontinues K-12 education services, CH can increase to meet additional need for skill building. 	<ul style="list-style-type: none"> • Child/ youth has successfully met their specific goal outlined in their service plan and no longer needs this service; OR • Child/ youth is no longer engaged in the service, despite multiple attempts on the part of the provider to apply reasonable engagement strategies; OR • Child/ youth moves to a certified residential setting

Additional Considerations for Service Authorization Decisions

Other Paid Supports	<ul style="list-style-type: none"> • Department of Health (DOH) Personal Care and Respite services may be utilized in many instances. CH should be used as described above and not in lieu of DOH Personal Care or Respite services or other available services (e.g., services available through a 1915c waiver). • CH services can be increased or faded as the individual's needs, outcomes, goals and paid and unpaid supports change. • Individuals with behavioral health issues should be connected to the appropriate behavioral health and/or crisis services, if available and appropriate to maximize support.
Natural Supports	<ul style="list-style-type: none"> • Families in caregiving roles or other naturally supportive living situations should receive the support needed to assist in creating and maintaining a stable environment. Relief for family members/ caregivers may be provided through Respite services. • A family's capacity to provide natural supports should be evaluated, with additional support being required if the family situation is destabilized due to mental health issues, the death of a family member or other stressors. • Additional support may also be required as the primary caregiver ages or when multiple members of the family require the support of a single caregiver.
Individual Needs	<ul style="list-style-type: none"> • Individuals may require reassessment when they: <ul style="list-style-type: none"> ○ Have significant/ complex medical or behavioral needs and are not presenting as clinically stable; OR ○ Have frequent use of hospital emergency rooms and inpatient services; OR ○ Require heightened levels of supervision such as being within line of sight or 1:1 within arm's length for safety

	<ul style="list-style-type: none"> Individualized support models may need a blend of DOH Personal Care, Respite services, and CH.
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Note: OPWDD Community Habilitation provider agencies are bound by MHL § 13.01 and MHL § 1.03(22) to only provide the Community Habilitation service to individuals with intellectual and developmental disabilities (I/DD). These approved provider agencies are not allowed to provide the service to individuals without an I/DD.

Day Habilitation

Definition

Assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills including communication, and travel that regularly takes place in a non-residential setting, separate from the person's private residence or other residential arrangement. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, community inclusion, relationship building, self-advocacy, and informed choice. Day Habilitation (DH) services must be provided to a child/youth at an OPWDD certified setting typically between the daytime hours of 9 a.m. and 3 p.m.

Service Components

Individual Day Habilitation (a one-to-one, individual-to-worker provided service with an hourly unit of service) and Group Day Habilitation services are furnished four or more hours per day on a regularly scheduled basis for one or more days per week or less frequently as specified in the participant's POC. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day).

A supplemental version of Individual and Group Day Habilitation is available for children/youth who do not reside in a certified setting. The supplemental Day Habilitation is provided outside the 9 a.m. to 3 p.m. weekday time period and includes later afternoon, evenings, and weekends. Day Habilitation and Supplemental Day Habilitation services cannot be delivered at the same time.

All Day Habilitation services (Group and Individual) have the same service description and focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the POC. In addition, Day Habilitation services may serve to reinforce skills, behaviors, or lessons taught in other settings. Provider agencies of Day Habilitation must develop a Day Habilitation service plan to document the child/youth's goal(s)/outcomes(s), health/safety needs required during the delivery of the service, and the necessary staff actions to assist the child/youth in reaching his/her Day Habilitation goal(s)/outcomes(s), and health/safety needs.

Modality

- Individual in-person service
- Group in-person service

Setting

Day Habilitation (DH) services are provided to a child at an OPWDD certified setting.

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration.

Limitations/Exclusions

Group and Individual DH cannot be billed as overlapping services. Any child/youth receiving HCBS under this waiver may receive this service. Service necessity criteria for this service requires that the child/youth must have a developmental delay justifying the need for the provision of Day Habilitation, but the child/youth may meet NF, ICF/IID, or Hospital LOC.

Day Habilitation services will not include funding for direct, hands-on physical therapy, occupational therapy, speech therapy, nutrition, or psychology services.

Children/youth have a maximum daily amount of services that are available to individuals based upon their residence. Individuals residing in certified settings are limited to a maximum of six hours of non-residential services (or its equivalent) which must commence no later than 3 p.m. on weekdays.

Supplemental DH services are those services provided on weekends and/or on weekdays with a service start time after 3 p.m. Supplemental DH services are not available to individuals residing in certified residential settings with paid, professional staff, because the certified residential habilitation provider is responsible for the habilitation needs of the individual on weekday evenings and anytime on weekends.

Certification/Provider Qualifications

Provider Agency Qualifications

New York State Office for People with Developmental Disabilities (OPWDD) Regional Office or non-profit organization certified by OPWDD.

OPWDD Regional Office

- OPWDD Regional Offices may provide Day Habilitation HCBS waiver services directly through its Regional Offices
- OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by DOH and the HHS Office of the Inspector General

Non-Profit Organization

- Certified by OPWDD to provide Day Habilitation
- OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by DOH and the HHS Office of the Inspector General
- Non-profit organizations include nonprofit corporations formed under New York State Law or authorized to do business in New York, local government units, or organizations created by an act of the New York State Legislature for charitable purposes, which include providing services to persons with developmental disabilities
- If the provider agency employs professional clinical staff, that staff person must have the appropriate credentials stipulated by the OPWDD and/or the NYS Department of Education under the following regulations and laws:
 - Nursing (8 NYCRR Part 64 and Education Law Title 8, Article 139)
 - Speech Language Pathologist (8 NYCRR Part 75 and Education Law Title 8, Article 159)
 - Psychology (8 NYCRR Part 72 and Education Law Title 8, Article 153)
 - Social Work (8 NYCRR Part 74 and Education Law Title 8, Article 154)
 - Rehab Counselor (14 NYCRR Part 679.99)
 - Dietetics/Nutrition (8 NYCRR Part 79 and Education Law Title 8, Article 157)
 - Occupational Therapy (8 NYCRR Part 76 and Education Law Title 8, Article 156)
 - Physical Therapy (8 NYCRR part 77 and Education Law Title 8, Article 136)
 - Applied Behavioral Sciences Specialist (8 NYCRR Part 79 and Education Law Title 8, Article 167)
 - Behavioral Intervention Specialist (14 NYCRR part 633-16.b(32))

Practitioners must operate in agencies that have been designated through the NYS Children's Provider Designation Review Team. This requires agencies to have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners must adhere to all Medicaid requirements in this Manual and in other applicable provider manuals, regulations, and statutes
- Provider agencies must adhere to cultural competency guidelines
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served
- The provider agency must ensure that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery
- The provider agency must ensure that practitioners maintain the licensure necessary to provide services under their scope of practice under State law, if applicable
- The provider agency must ensure that any insurance required by the designating state agency is obtained and maintained

- The provider agency must ensure that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency

Additional information and application for Children's HCBS can be found on the [DOH website](#).

Individual Staff/Agency Qualifications

- Providers must have appropriate license, certification, and/or approval in accordance with State requirements
- Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8 and the Direct Support Professionals Core Competencies curriculum

Additional information can be found in the [DSP Core Competencies section of the OPWDD website](#).

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Day Habilitation	<ul style="list-style-type: none"> • Mandated Reporter 	<ul style="list-style-type: none"> • Prior to Service Delivery
	<ul style="list-style-type: none"> • Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • Training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix E.

Service Billing Details

Rate Code Descriptions

The table below shows the rate code, CPT code, and modifier code combinations that will be required under Medicaid Managed Care. Providers will use these coding combinations to indicate to the MMCP that the claim is for a children/youth service and is to be paid at the government rate. The procedure and modifier code combinations must be adhered to by both provider and MMCP to ensure appropriate rate payment.

In acknowledgement of the need for checks against fraud and abuse, but to ensure a child/youth's access to services, service utilization in excess of the "soft" unit (i.e., annual, daily, dollar amount) limits must be based on medical necessity. Documentation of the medical necessity for extended durations must be kept on file in the child/youth's record. HCBS should be initially authorized for no more than six months at a time and

based on each participant's unique needs. To exceed billing limits for children/youth enrolled in managed care, providers must contact the MMCP to receive guidance regarding the Plan's specific documentation requirements in these instances ; for children/youth enrolled in FFS, HCBS providers must maintain documentation from a licensed professional that outlines the need to exceed the service limit (e.g., copy of an assessment from a licensed professional; letter from a licensed professional that clearly describes the need for additional units of service, etc.).

In addition to requiring concurrent utilization review and authorization, the MMCP may conduct post-payment administrative reviews to ensure services were provided appropriately.

Day Habilitation					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Day HCBS Habilitation	7933	T2020	HA	15 minutes	24/day
Day HCBS Habilitation - Group of 2	7934	T2020	HA, UN	15 minutes	24/day
Day HCBS Habilitation - Group of 3	7935	T2020	HA, UP	15 minutes	24/day

Caregiver/Family Advocacy and Support Services

Definition

Caregiver/Family Advocacy and Support Services enhance the child/youth's ability, regardless of disability (developmental, physical, and/or behavioral), to function as part of a caregiver/family unit and enhance the caregiver/family's ability to care for the child/youth in the home and/or community as well as, provides the child/youth, family, caregivers, and collateral contacts (family members, caregivers, and other stakeholders identified on the child/youth's POC) with techniques and information not generally available so that they can better respond to the needs of the participant. These services are intended to assist the child/youth, family/caregiver, and collateral contacts in understanding and addressing the participant's needs related to their disability(ies).

The use of this service may appropriately be provided to prevent problems in community settings when the child/youth is experiencing difficulty.

The POC objectives must clearly state how the service can prevent as well as ameliorate existing problems and to what degree. This service cannot be used to develop an Individualized Education Program (IEP), the plan for students with disabilities who meet the federal and state requirements for special education, or to

provide special education services to the child/youth. Participating in community events and integrated interests/occupations are important activities for all children/youth, including those with disabilities (developmental, physical, and/or behavioral health in origin). Success in these activities is dependent not only on the child/youth, but on the people, who interact with and support the child/youth in these endeavors.

Caregiver/Family Advocacy and Support Services improve the child/youth's ability to gain from the community experience and enables the child/youth's environment to respond appropriately to the child/youth's disability and/or healthcare issues.

Note: This service is not the State Plan service of Family Peer Support Services which must be delivered by a certified/credentialed Family Peer with lived experience.

Service Components

Based upon the Caregiver/Family Advocacy and Support Services plan developed by the child/youth and caregiver/family team; this service provides opportunities to:

- Interact and engage with family/caregivers and children/youth to offer educational, advocacy, and support resources to develop family/caregivers' ability to independently access community services and activities
- Maintain and encourage the caregivers'/families' self-sufficiency in caring for the child/youth in the home and community
- Address needs and issues of relevance to the caregiver/family unit as the child/youth is supported in the home and community
- Educate and train the caregiver/family unit on available resources so that they might better support and advocate for the needs of the child and appropriately access needed services
- Provide guidance in the principles of children's chronic condition or life-threatening illness
- Training (one-on-one or group) for the child/youth and/or the family/caregiver regarding methods and behaviors to enable success in the community; each group must not exceed 12 participants (enrollees and collaterals)
- Direct self-advocacy training in the community with collateral contacts regarding the child/youth's disability(ies) and needs related to his or her health care issues
- Self-advocacy training for the child/youth and/or family/caregiver, including during community transitions

When outlined in the child/youth's POC, the service can be delivered to multiple family members or other identified resources for the child/youth by more than one practitioner to address the child/youth's needs by educating, engaging, and guiding their families to ensure that the child/youth and family's needs are met. In instances where two practitioners are required to meet the needs of the child/family, and the encounters occur at the same date and time, the agency can bill for both practitioners in one claim by adding the time the service was delivered by each practitioner into a combined claim. If one practitioner delivers the services to a child/youth and/or multiple family members/resources at the same date and time, the claim should reflect the exact time spent as a single encounter.

Modality

- Individual in-person intervention
- Group in-person intervention (no more than three HCBS eligible children/families)

Note: Services can be delivered with or without the child/youth present.

Setting

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community-based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

- This service cannot be delivered or billed while an enrolled child/youth is in an ineligible setting, including hospitalization
- Caregiver/Family Advocacy and Support Services cannot duplicate or replace special education and related services that are otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA)
- Caregiver/Family Advocacy and Support Services cannot duplicate or replace existing and required care management services provided through HH/C-YES
- Caregiver/Family Advocacy and Support Services are limited to six hours per day

Certification/Provider Qualifications

Provider Agency Qualifications

Practitioners must operate in agencies that have been designated through the NYS Children's Provider Designation Review Team. This requires that agencies have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners must adhere to all Medicaid requirements in this Manual and in other applicable provider manuals, regulations, and statutes
- Provider agencies must adhere to cultural competency guidelines
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served
- The provider agency must ensure that staff receive Mandated Reporting training prior to service delivery

- The provider agency must ensure that practitioners maintain the licensure necessary to provide services under their scope of practice under State law, if applicable
- The provider agency must ensure that any insurance required by the designating state agency is obtained and maintained
- The provider agency must ensure that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency

Additional information and application for Children's HCBS can be found on the [DOH website](#).

Individual Staff Qualifications:

- **Level 1 Minimum Qualifications:** Requires a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g., SACC or CDOS) with related human service experience
- **Level 1 Preferred Qualifications:** Experience working with children/youth
- **Level 2 Minimum Qualifications:** Requires a bachelor's degree plus two years of related experience
- **Level 2 Preferred Qualifications:** Requires a master's degree in education, or a master's degree in a human services field plus one year of applicable experience

Supervisor Qualifications:

- **Level 1 Minimum Qualifications:** Requires a bachelor's degree with one year of experience in human services working with children/youth
- **Level 1 Preferred Qualifications:** Two years' experience in human services working with children/youth
- **Level 2 Minimum Qualifications:** Requires a master's degree with one year of experience or a bachelor's degree with four years of experience in human services working with children/youth
- **Level 2 Preferred Qualifications:** Master's degree with two years of experience in human services working with children/youth

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Caregiver/Family Advocacy and Support Services	<ul style="list-style-type: none"> • Mandated Reporter • Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • Prior to Service Delivery • Training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix E.

Service Billing Details

Rate Code Description

The table below shows the show the rate code, CPT code, and modifier code combinations that will be required under Medicaid Managed Care. Providers will use these coding combinations to indicate to the MMCP that the claim is for a children/youth's service and is to be paid at the government rate. The procedure and modifier code combinations must be adhered to by both provider and MMCP to ensure appropriate rate payment.

In acknowledgement of the need for checks against fraud and abuse, but to ensure a child/youth's access to services, service utilization in excess of the "soft" unit (i.e., annual, daily, dollar amount) limits must be based on medical necessity. Documentation of the medical necessity for extended durations must be kept on file in the child/youth's record. HCBS should be initially authorized for no more than six months at a time and based on each participant's unique needs. To exceed billing limits for children/youth enrolled in managed care, providers must contact the MMCP to receive guidance regarding the Plan's specific documentation requirements in these instances ; for children/youth enrolled in FFS, HCBS providers must maintain documentation from a licensed professional that outlines the need to exceed the service limit (e.g., copy of an assessment from a licensed professional; letter from a licensed professional that clearly describes the need for additional units of service, etc.).

In addition to requiring concurrent utilization review and authorization, the MMCP may conduct post-payment administrative reviews to ensure services were provided appropriately.

Caregiver/Family Advocacy and Support Services

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Caregiver/Family Advocacy and Support Services – L1 Individual	8003	H2014	UK, HA	15 minutes	24/day
Caregiver/Family Advocacy and Support Services – L1 Group of 2	8004	H2014	HA, UK, UN	15 minutes	24/day
Caregiver/Family Advocacy and Support Services – L1 Group of 3	8005	H2014	HA, UK, UP	15 minutes	24/day

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Caregiver/Family Advocacy and Support Services – L2 Individual	8009	H2015	HA	15 minutes	24/day
Caregiver/Family Advocacy and Support Services – L2 Group of 2	8010	H2015	HA, UN	15 minutes	24/day
Caregiver/Family Advocacy and Support Services – L2 Group of 3	8011	H2015	HA, UP	15 minutes	24/day

Respite

Definition

This service focuses on short-term assistance provided to children/youth, regardless of disability (developmental, physical and/or behavioral), because of the absence of or need for relief of the child/youth or the child/youth's family caregiver. Such services can be provided in a planned mode or delivered in a crisis situation. Respite workers supervise the child/youth and engage the child/youth in activities that support his/her and/or primary caregiver/family's constructive interests and abilities.

Respite providers offer services with a level of expertise in understanding and implementing behavioral/developmental interventions required to support optimal functioning for children/youth. Respite providers regularly communicate the details of the child/youth's intervention plan so that there is a carryover of skill from the respite source to the caregivers and treatment providers.

Service Components

Planned

Planned Respite services provide planned short-term relief for the child/youth or family/primary caregivers to enhance the family/primary caregiver's ability to support the child/youth's functional, developmental, behavioral health, and/or health care needs. The service is direct care for the child/youth by individuals trained to support the child/youth's needs. This support may occur in short-term increments of time (usually during the day) or on an overnight or longer-term increment. Planned Respite activities support the POC goals and include providing supervision and activities that match the child/youth's developmental stage and continue to maintain the child/youth health and safety.

Respite services may be delivered in a home or residence by qualified practitioners, out-of-home/residence by staff in community-based sites (e.g., community centers, camps, parks), or in allowable facilities.

Crisis

Crisis Respite is a short-term care and intervention strategy for children/youth and their families that helps to alleviate the risk for an escalation of symptoms, a loss of functioning, and/or a disruption in a stable living environment. It may be used when challenging behavioral or situational crises occur that the child/youth and/or family/caregiver is unable to manage without intensive assistance and support. Crisis Respite can also be used for crisis intervention or from visiting the emergency room. Crisis Respite should be included on the POC to the extent that it is an element of the crisis plan or risk mitigation strategy. Crisis Respite should only be used in response to an immediate crisis.

Crisis Respite services may be delivered in a home or residence by qualified practitioners, out-of-home/residence by staff in community-based sites, or in allowable facilities. Services offered may include site-based crisis residence, monitoring for high-risk behavior, health and wellness skill building, wellness activities, family/caregiver support, conflict resolution, and other services as needed.

Ongoing communication between child/youth or the family/primary caregiver receiving Crisis Respite for their child, the Crisis Respite staff, and the child/youth's established behavioral health and healthcare providers is required to assure collaboration and continuity in managing the crisis situations and identifying subsequent support and service needs.

At the conclusion of a Crisis Respite period, Crisis Respite staff, together with the child/youth and family/primary caregiver, and his or her established behavioral health or health care providers when needed, will make a determination as to the continuation of necessary care and make recommendations for modifications to the child's POC. Children/youth are encouraged to receive Crisis Respite in the most integrated and cost-effective settings appropriate to meet their respite needs. Out-of-home Crisis Respite is not intended as a substitute for permanent housing arrangements.

Modality

Planned Day Respite, Planned Overnight Respite, Crisis Day Respite, Crisis Overnight Respite:

These services may be delivered with support of staffing ratios necessary to keep the child/youth, and other children/youth in the environment, safe and as indicated in the child/youth's POC overseen by the Respite provider.

Overnight Respite is defined as Respite services provided to a person on two consecutive days when Respite staff are providing oversight to a participant during

nighttime hours. Overnight Respite should follow the general limits for respite (see below).

Overnight Respite should be used in instances to enhance the family/primary caregiver's ability to support the child/youth's functional, developmental, behavioral health, and/or health care needs or to help alleviate the risk for an escalation of symptoms, a loss of functioning, and/or a disruption in a stable living environment. Overnight Respite is not a substitute for childcare.

Setting

Planned or Crisis Day Respite services can be provided in the home of an eligible child/youth or a community setting. Community settings may include areas where a child/youth lives, attends school, works, engages in services and/or socializes and is in compliance with CMS Final Rule (§441.301(c)(4) and (§441.710), HCBS Settings Rule (Appendix B).

Note: a provider can be designated for Crisis or Planned Respite without an overnight setting; however, they will only be authorized to provide Respite that does not include an overnight stay or overnight service provision. If the Respite service is provided overnight, it can only be done so in an authorized overnight setting, and that setting must be a licensed/certified facility as outlined below.

Planned or Crisis Overnight Respite settings include those licensed or certified by OCFS, OMH, or OPWDD and designated to provide Respite services. Please note there is an exemption in the CMS HCBS Final Rule (March 16, 2014) for allowable Respite care settings.

- OMH licensed Community Residence (community-based or state-operated), including Crisis Residence, which has an OMH Operating Certificate demonstrating compliance with 14 NYCRR 594
- OCFS Licensed agency boarding home, a group home, a group residence, or an institution and certified foster boarding homes
- OPWDD certified residential setting where the individual does not permanently reside (i.e., Family Care Home; Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IDD); Individualized Residential Alternative (IRA) or Community Residence (CR); or Free-Standing Respite facility under the auspices of OPWDD)

Limitations/Exclusions

- Services to children/youth in foster care must comply with Part 435 of 18 NYCRR. Respite is not an allowable substitute for permanent housing arrangements.
- For Respite services that may be provided as crisis or overnight, Federal Financial Participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

- It is the responsibility of the HHCM/C-YES upon referral to ensure that Respite providers have adequate training and knowledge to address the individual child/youth's needs (including but not limited to physical and/or medical needs such as medications or technology), *OR* have made arrangements for an appropriately trained and knowledgeable individual to address the individual child/youth's needs (including but not limited to physical and/or medical needs such as medications or technology). Examples include arrangement of an approved Private Duty Nurse for a technology dependent child/youth while in a Respite setting.
- Respite is not a substitute for child care and should only be used in instances to enhance the family/primary caregiver's ability to support the child/youth's functional, developmental, behavioral health, and/or health care needs. The needs of the child/youth should be driving this service and not the availability of the family/primary caregiver to supervise the child/youth. For example, accompanying a child/youth to a community activity at a local park from 5 PM – 7 PM would be billable if aligned with the child/youth's POC and in alignment with the f/s/d outlined in the HCBS Service Plan, whereas the provider staying in the home from 8 PM – 10 PM to provide supervision after bedtime would not be billable.

Certification/Provider Qualifications

Provider Agency Qualifications

Practitioners must operate in agencies that have been designated through the NYS Children's Provider Designation Review Team. This requires that agencies have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners must adhere to all Medicaid requirements in this Manual and in other applicable provider manuals, regulations, and statutes.
- Provider agencies must adhere to cultural competency guidelines
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served
- The provider agency must ensure that staff receive Mandated Reporting training prior to service delivery
- The provider agency must ensure that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable
- The provider agency must ensure that any insurance required by the designating state agency is obtained and maintained
- The provider agency must ensure that any safety precautions needed to protect the child/youth population served are taken as necessary and required by the designating State agency

Additional information and application for Children's HCBS can be found on the [DOH website](#).

For Overnight Planned or Crisis Respite, the designated provider must meet the Provider Agency Qualifications above AND must be one of the following:

- OMH-certified Community Residence: (community-based or State-operated) including Crisis Residence
- OCFS licensed/certified setting including agency boarding home, a group home, a group residence, or an institution
- OPWDD certified residential setting

Individual Staff Qualifications

- **Provision of service in child's residence or other community-based setting (e.g., park, shopping center, etc.)**
 - Respite providers are paraprofessionals with a high school diploma or equivalent and with appropriate skills and training. It is the responsibility of the HHCM/C-YES to ensure that providers have adequate training and knowledge to address the individual child/youth's needs (including but not limited to physical and/or medical needs such as medications or technology).
 - Experience working with children/youth (preference given to those with experience working with children/youth with special needs)
 - A high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS)
- **Provision of service outside child/youth's residence and in an allowable licensed/certified setting**
 - In a foster boarding home: Respite providers must be a Licensed Foster Parent pursuant to Part 435 of 18 NYCRR
 - In a OCFS licensed/certified setting: Respite providers are paraprofessionals with a high school diploma or equivalent and with appropriate skills and training
 - In an OMH-certified Community Residence: (community-based or State-operated), including Crisis Residence, which has an OMH Operating Certificate demonstrating compliance with 14 NYCRR 594: Respite workers must be staff of the licensed program
 - In an OPWDD-certified setting: (community-based or State-operated), Family Care Home, Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IDD); Individualized Residential Alternative (IRA) or Community Residence (CR); or Free-Standing Respite facility under the auspices of OPWDD; Respite workers must be staff of the certified program.

Supervisor Qualifications

Minimum Qualifications: An individual with a bachelor's degree and one year of experience in human services working with children/youth

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Respite (Crisis/Planned)	<ul style="list-style-type: none"> • Mandated Reporter 	<ul style="list-style-type: none"> • Prior to Service Delivery
	<ul style="list-style-type: none"> • Personal Safety • Safety in the Community • Strength Based Approaches • OMH-recommended Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • Training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix E.

Service Billing Details

Rate Code Description

The two tables below show the show the rate code, CPT code, and modifier code combinations that will be required under Medicaid Managed Care. Providers will use these coding combinations to indicate to the MMCP that the claim is for a children/youth's service and is to be paid at the government rate. The procedure and modifier code combinations must be adhered to by both provider and MMCP to ensure appropriate rate payment.

In acknowledgement of the need for checks against fraud and abuse, but to ensure a child/youth's access to services, service utilization in excess of the "soft" unit (i.e., annual, daily, dollar amount) limits must be based on medical necessity. Documentation of the medical necessity for extended durations must be kept on file in the child/youth's record. HCBS should be initially authorized for no more than six months at a time and based on each participant's unique needs. To exceed billing limits for children/youth enrolled in managed care, providers must contact the MMCP to receive guidance regarding the Plan's specific documentation requirements in these instances ; for children/youth enrolled in FFS, HCBS providers must maintain documentation from a licensed professional that outlines the need to exceed the service limit (e.g., copy of an assessment from a licensed professional; letter from a licensed professional that clearly describes the need for additional units of service, etc.).

In addition to requiring concurrent utilization review and authorization, the MMCP may conduct post-payment administrative reviews to ensure services were provided appropriately.

Respite - Planned					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit

Planned Respite - Individual (up to 6 hours)	8023	S5150	HA	15 minutes	24/day
Planned Respite - Individual per diem (over 6 up to 12 hours)	8024	S5151	HA	Per Diem	1/day
Planned Respite – Individual per diem (over 12 up to 24 hours)	8025	S5151	HA, HK	Per diem	1/day
Planned Respite - Group per diem (over 6 up to 12 hours)	8026	S5150	HA, HK, HQ	Per diem	1/day
Planned Respite - Group (up to 6 hours)	8027	S5150	HA, HQ	15 minutes	24/day

Respite - Crisis

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Crisis Respite – (up to 6 hours)	8028	S5150	HA, ET	15 minutes	24/day
Crisis Respite - (over 6 up to 12 hours)	8029	S5151	HA, ET	Per Diem	1/day
Crisis Respite - Individual (over 12 up to 24 hours)	8030	S5151	HA, ET, HK	Per Diem	1/day

Annual units for Planned and Crisis Respite are limited to 14 days (full per diems) during the calendar year or 1,344 15-minute units annually. The cumulative total hours of all Planned and Crisis Respite services received may not exceed the 14 day/1,344 15- minute unit annual amount without medical necessity documented in the child's case record. If the child is enrolled in a MMCP, approval from the MMCP must also be documented in the child's case record.

The following are examples of permissible Respite billing combinations (total 1,344 15-minute units OR 14 per diems during the calendar year):

- 48 15-minute units/week for 28 weeks
- One 24-hour per diem units and 22 15-minute units/week for 52 weeks with 104 additional 15-minute units to be used throughout the year
- 24 hours for 14 days

Guidance on Per Diem Billing

It is permissible to provide and bill for another HCBS while overnight Respite is also provided at the full per diem rate during the same day, provided that the child/youth is in the care of the Respite provider for at least 12 cumulative hours. For example, a provider can bill for the per diem Crisis Respite rate while the child/youth attends a necessary and/or regularly scheduled medical appointment, provided that the child/youth is in the care of the Crisis Respite provider for at least 12 cumulative hours outside of the time the child/youth spent at the medical appointment. If the child/youth is in the direct care of the Respite provider for less than 12 cumulative hours while receiving other services (e.g., medical services/appointments), then the 6 – 12 hour or up to 6 hour rate should be billed. Providers must properly document why the break in service was needed and necessary during the provision of overnight respite.

As indicated in the Respite limit guidance noted above, the total Planned and Crisis Respite claims cannot total more than 336 hours within the calendar year.

Prevocational Services

Definition

Prevocational Services are individually designed to prepare a youth (age 14 or older) to engage in paid work, volunteer work, or career exploration. Prevocational Services are not job-specific, but rather are geared toward facilitating success in any work environment for youth whose disabilities do not permit them access to other prevocational services. The service will be reflected in youth's POC and must be directed to teaching skills rather than explicit employment objectives. In addition, Prevocational Services assist with facilitating appropriate work habits, acceptable job behaviors, and learning job production requirements.

Service Components

Prevocational Services may include volunteer work, such as learning and training activities that prepare a person for entry into the paid workforce. Prevocational Services should enable each participant to attain the highest level of work in the most integrated setting and with the job matched to the participant's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines from the U.S. Department of Labor. Services are intended to develop and teach general skills. Examples include, but are not limited to:

- Ability to communicate effectively with supervisors, co-workers, and customers
- Generally accepted community workplace conducts and dress

- Ability to follow directions
- Ability to attend to and complete tasks
- Punctuality and attendance
- Appropriate behaviors in and outside the workplace
- Workplace problem solving skills and strategies
- Mobility training
- Career planning
- Proper use of job-related equipment and general workplace safety

Prevocational Services include activities that are not primarily directed at teaching skills to perform a particular job, but at underlying habilitative goals (e.g., attention span, motor skills, interpersonal relations with co-workers and supervisors) that are associated with building skills necessary to perform work and optimally to perform competitive, integrated employment.

- Resume writing, interview techniques, role play, and job application completion
- Exploring career options, facilitating appropriate work habits, acceptable job behaviors, and learning job production requirements
- Assisting in identifying community service opportunities that could lead to paid employment
- Helping youth to connect their educational plans to future career/vocational goals
- Helping youth to complete college, technical school, or other applications to continue formal education/training
- Helping youth to apply for financial aid or scholarship opportunities

Documentation is maintained that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Modality

This service may be delivered in a one-to-one session or in a group setting of two or three participants.

Setting

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community-based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

Documentation is maintained that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Prevocational services will not be provided to an HCBS participant if:

- Special education and related services are otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA), and the provision of HCBS Prevocational services would be duplicative of such services.
- Vocational rehabilitation services are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (Access VR), and the provision of HCBS Prevocational services would be duplicative of such services.
- Vocational services are provided in facility-based work settings that are not integrated settings in the general community workforce.

Certification/Provider Qualifications

Provider Agency Qualifications

Practitioners must operate in agencies that have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners must adhere to all Medicaid requirements in this Manual and in other applicable provider manuals, regulations, and statutes
- Provider agencies must adhere to cultural competency guidelines
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served
- The provider agency must ensure that staff receive Mandated Reporting training prior to service delivery
- The provider agency must ensure that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable
- The provider agency must ensure that any insurance required by the designating state agency is obtained and maintained
- The provider agency must ensure that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency

Additional information and application for Children's HCBS can be found on the [DOH website](#).

Individual Qualifications

- **Minimum Qualifications:** An individual with an associate's degree and one year of human service experience

- **Preferred Qualifications:** Bachelor's degree with one year of experience in human services working with children/youth

Supervisor Qualifications

- **Minimum Qualifications:** An individual with a bachelor's degree and three years of experience in human services
- **Preferred Qualifications:** Master's degree with one year of experience in human services working with children/youth

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Prevocational Services	<ul style="list-style-type: none"> • Mandated Reporter 	<ul style="list-style-type: none"> • Prior to Service Delivery
	<ul style="list-style-type: none"> • Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • Training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix E.

Service Billing Details

Rate Code Description

The table below shows the show the rate code, CPT code, and modifier code combinations that will be required under Medicaid Managed Care. Providers will use these coding combinations to indicate to the MMCP that the claim is for a children/youth's service and is to be paid at the government rate. The procedure and modifier code combinations must be adhered to by both provider and MMCP to ensure appropriate rate payment.

In acknowledgement of the need for checks against fraud and abuse, but to ensure a child/youth's access to services, service utilization in excess of the "soft" unit (i.e., annual, daily, dollar amount) limits must be based on medical necessity. Documentation of the medical necessity for extended durations must be kept on file in the child/youth's record. HCBS should be initially authorized for no more than six months at a time and based on each participant's unique needs. To exceed billing limits for children/youth enrolled in managed care, providers must contact the MMCP to receive guidance

regarding the Plan's specific documentation requirements in these instances ; for children/youth enrolled in FFS, HCBS providers must maintain documentation from a licensed professional that outlines the need to exceed the service limit (e.g., copy of an assessment from a licensed professional; letter from a licensed professional that clearly describes the need for additional units of service, etc.).

In addition to requiring concurrent utilization review and authorization the MMCP may conduct post-payment administrative reviews to ensure services were provided appropriately.

Prevocational Services					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Prevocational Services - Individual	8006	T2015	HA	15 Minutes	8/day
Prevocational Services - Group of 2	8007	T2015	HA, UN	15 Minutes	8/day
Prevocational Services - Group of 3	8008	T2015	HA, UP	15 Minutes	8/day

Supported Employment

Definition

Supported Employment services are individually designed to prepare youth with disabilities (age 14 or older) to engage in paid work. Supported Employment services provide assistance to participants with disabilities as they perform in a work setting.

Supported Employment provides ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Supported Employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits support, training and planning, transportation, career advancement services,

and other workplace support services including services not specifically related to job skill training that enable the participant to successfully integrate into the job setting.

Supported Employment services may also include services and supports that assist the participant in achieving self-employment through the operation of a business including home-based self-employment. However, Medicaid funds are not used to defray the expenses associated with starting up or operating a business.

In addition to the need for an appropriate job match that meets the individual's skills and interests, individuals may also need long term employment support to successfully maintain a job due to the ongoing nature of the HCBS participant's support needs, changes in life situations, or evolving and changing job responsibilities.

Service Components

Supported employment services may be provided in a variety of settings, particularly work sites. Supported employment services include the following:

- Supervision and training that are not job-related
- Intensive ongoing support
- Transportation to and from the job site
- Interface with employers regarding the individual's disability(ies) and needs related to healthcare issue(s)
- Other activities needed to sustain paid work (e.g., employment assessment, job placement, and/or adaptive/assistive equipment and/or technology necessary for employment)
- Job finding and development training in work behaviors
- Assessing the interest and fit of an individual for particular job opportunities, staff work with employers and job sites preparing them to be able to make necessary and reasonable accommodations
- On-site support for the individual as they learn specific job tasks
- Monitoring through on-site observation and through communication with job supervisors and employers

Modality

- Individual in-person intervention

Setting

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community-based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly

defined, and can include families created through birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

Supported Employment service will not be provided to an HCBS participant if:

- Special education and related services are otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA), and the provision of Supported Employment would be duplicative of such services.
- Vocational rehabilitation services are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973, and the provision of Supported Employment would be duplicative of such services.
- Supported employment does not include facility based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.
- Supported employment does not include payment for supervision, training, support, and/or adaptations typically available to other workers without disabilities filling similar positions in the business.
- Supported employment does not include volunteer work. Such volunteer learning and un-paid training activities that prepare a person for entry into the paid workforce are addressed through Prevocational services.

Medicaid funding cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in Supported Employment
- Payments that are passed through to users of Supported Employment services

Supported Employment is limited to three hours per day.

Certification/Provider Qualifications

Provider Agency Qualifications

Practitioners must operate in agencies that have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners must adhere to all Medicaid requirements in this Manual and in other applicable provider manuals, regulations, and statutes
- Provider agencies must adhere to cultural competency guidelines

- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served
- The provider agency must ensure that staff receive Mandated Reporting training prior to service delivery
- The provider agency must ensure that practitioners maintain the licensure necessary to provide services under their scope of practice under State law, if applicable
- The provider agency must ensure that any insurance required by the designating State agency is obtained and maintained
- The provider agency must ensure that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency

Additional information and application for Children's HCBS can be found on the [DOH website](#).

Individual Qualifications

- **Minimum Qualifications:** An individual with an Associate's degree and one year of human service experience
- **Preferred Qualifications:** Bachelor's degree with one year of experience in human services working with children/youth

Supervisor Qualifications

- **Minimum Qualifications:** An individual with a Bachelor's degree and three years of experience in human services
- **Preferred Qualifications:** Master's degree with one year of experience in human services working with children/youth

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Supported Employment	<ul style="list-style-type: none"> • Mandated Report • Personal Safety/ Safety in the Community • Strength Based Approaches • OMH-recommended Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • Prior to Service Delivery • Training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix E.

Service Billing Details

Rate Code Description

The table below shows the show the rate code, CPT code, and modifier code combinations that will be required under Medicaid Managed Care. Providers will use these coding combinations to indicate to the MMCP that the claim is for a children/youth's service and is to be paid at the government rate. The procedure and modifier code combinations must be adhered to by both provider and MMCP to ensure appropriate rate payment.

In acknowledgement of the need for checks against fraud and abuse, but to ensure a child/youth's access to services, service utilization in excess of the "soft" unit (i.e., annual, daily, dollar amount) limits must be based on medical necessity. Documentation of the medical necessity for extended durations must be kept on file in the child/youth's record. HCBS should be initially authorized for no more than six months at a time and based on each participant's unique needs. To exceed billing limits for children/youth enrolled in managed care, providers must contact the MMCP to receive guidance regarding the Plan's specific documentation requirements in these instances ; for children/youth enrolled in FFS, HCBS providers must maintain documentation from a licensed professional that outlines the need to exceed the service limit (e.g., copy of an assessment from a licensed professional; letter from a licensed professional that clearly describes the need for additional units of service, etc.).

In addition to requiring concurrent utilization review and authorization the MMCP may conduct post-payment administrative reviews to ensure services were provided appropriately.

Supported Employment is billed as one service and can be delivered with or without the child/youth present.

Supported Employment					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Supported Employment	8015	H2023	HA	15 minutes	12/day

Palliative Care – Expressive Therapy

Definition

Palliative Care is specialized medical care focused on providing relief from the symptoms and stress of a chronic medical, physical, or developmental condition or life-threatening illness. The goal of Palliative Care services is to improve quality of life for both the child/youth and the family. Palliative Care is provided by a specially trained team of doctors, nurses, social workers, and other specialists who work together with a child/youth's doctors to provide an extra layer of support. It is appropriate at any stage

of a chronic medical, physical, or developmental condition or life-threatening illness and can be provided along with curative treatment.

Children/youth must meet LOC functional criteria and suffer from the symptoms and stress of a chronic medical, physical, or developmental condition or life-threatening illness.

The HHCM or C-YES will assist the family with obtaining a doctor's written order including justification for Expressive Therapy from a Physician, Physician Assistant, Nurse Practitioner, Occupational Therapist, Physical Therapist or Psychiatrist. This written order is to be included with the child/youth's POC and made available to the MMCP as needed.

Expressive Therapy (art, music, and play) helps children/youth better understand and express their reactions through creative and kinesthetic treatment.

Expressive therapy helps children/youth to feel empowered in their own creativity, control, and aid in their communication of their feelings when their life and body may be rapidly changing during the stressful time of undergoing a chronic condition and/or life-threatening illness and the trauma that often comes with its treatment. Whether through music, art, and/or play therapy, the child/youth may find an outlet that allows them to express their emotions safely and have a medium where they have complete control to play and explore with abandon. The family can participate as well, whether in the form of memories shared together or by tangible objects made by the child/youth they can hold onto - scrapbooks, paintings, or sculpture - mementos that tell their child/youth's life from their perspective and aid in their family's own journey of grief and loss.

Service Components

Expressive Therapy (art, music and play) helps children/youth better understand and express their feelings, emotions, behaviors, etc. through creative and kinesthetic treatment.

Modality

- **Expressive Therapy (art, music and play) – 1:1**

Setting

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community-based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

Palliative Care Expressive Therapy benefits may not duplicate Hospice or other State Plan benefits accessible to participants.

Limited to the lesser of four appointments per month or 48 units per calendar year. This limit can be exceeded when medically necessary.

Certification/Provider Qualifications

Provider Agency Qualifications

Certified Home Health Agency (CHHA), Hospice Organization, Article 28 Clinic, and/or designated through the NYS Children's Provider Designation Review Team.

This requires agencies have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners adhere to all Medicaid requirements in this Manual and in other applicable provider manuals, regulations, and statutes
- Provider agencies adhere to cultural competency guidelines
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served
- The provider agency ensures that staff receive Mandated Reporting training prior to service delivery
- The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable
- The provider agency ensures that any insurance required by the designating State agency is obtained and maintained
- The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency

Additional information and application for Children's HCBS can be found on the [DOH website](#).

Individual Staff Qualifications

- **Minimum Qualifications:**
 - An individual with a minimum of one year working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care
 - Child Life Specialist with certification through the Child Life Council; Creative Arts Therapist licensed by the State of New York; Music Therapist with a Bachelor's Degree from a program recognized by the NYS Education Department; Play Therapist with a Master's Degree from a program recognized by the New York State Education Department;

- current Play Therapist Registration conferred by the Association for Play Therapy (Expressive Therapy (Art, Music, and Play))
- Direct service workers must have background checks
- Student interns practicing within the scope of the New York State Education law and supervised by a licensed practitioner in that profession can deliver HCBS; student interns and limited permittees can treat Medicaid enrollees under the supervision of a licensed practitioners in that profession who must be enrolled as a Medicaid provider

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Palliative Care	<ul style="list-style-type: none"> • Mandated Reporter 	<ul style="list-style-type: none"> • Prior to Service Delivery
	<ul style="list-style-type: none"> • Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • Training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix E.

Service Billing Details

Rate Code Description

The table below shows the show the rate code, CPT code, and modifier code combinations that will be required under Medicaid Managed Care. Providers will use these coding combinations to indicate to the MMCP that the claim is for a children/youth's service and is to be paid at the government rate. The procedure and modifier code combinations must be adhered to by both provider and MMCP to ensure appropriate rate payment.

In acknowledgement of the need for checks against fraud and abuse, but to ensure a child/youth's access to services, service utilization in excess of the "soft" unit (i.e., annual, daily, dollar amount) limits must be based on medical necessity. Documentation of the medical necessity for extended durations must be kept on file in the child/youth's record. HCBS should be initially authorized for no more than six months at a time and based on each participant's unique needs. To exceed billing limits for children/youth enrolled in managed care, providers must contact the MMCP to receive guidance regarding the Plan's specific documentation requirements in these instances ; for children/youth enrolled in FFS, HCBS providers must maintain documentation from a licensed professional that outlines the need to exceed the service limit (e.g., copy of an

assessment from a licensed professional; letter from a licensed professional that clearly describes the need for additional units of service, etc.).

In addition to requiring concurrent utilization review and authorization the MMCP may conduct post-payment administrative reviews to ensure services were provided appropriately.

Palliative Care – Expressive Therapy					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Palliative Care - Expressive Therapy	8019	96159	TJ	15 minutes	48/year

PALLIATIVE CARE – MASSAGE THERAPY

Definition

Palliative Care is specialized medical care focused on providing relief from the symptoms and stress of a chronic medical, physical, or developmental condition or life-threatening illness. The goal of Palliative Care services is to improve quality of life for both the child/youth and the family. Palliative Care is provided by a specially trained team of doctors, nurses, social workers, and other specialists who work together with a child/youth's doctors to provide an extra layer of support. It is appropriate at any stage of a chronic medical, physical, or developmental condition or life-threatening illness and can be provided along with curative treatment.

Children/youth must meet LOC functional criteria and suffer from the symptoms and stress of a chronic medical, physical, or developmental condition or life-threatening illness.

The HHCM or C-YES will assist the family with obtaining a doctor's written order including justification for Massage Therapy from a Physician, Physician Assistant, Nurse Practitioner, Occupational Therapist, Physical Therapist or Psychiatrist. The written order is to be included with the child/youth's POC and made available to the MMCP as needed.

Massage Therapy: To improve muscle tone, circulation, range of motion, and address physical symptoms related to illness as well as provide physical and emotional comfort, pain management, and restore the idea of healthy touch for children/youth who are dealing with treatments that may involve painful interventions and ongoing and/or past trauma.

Service Components

Massage Therapy – To improve muscle tone, circulation, range of motion and address physical symptoms related to their chronic medical, physical, or developmental condition or life-threatening illness.

Modality

- **Massage Therapy** – 1:1

Setting

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community-based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

Palliative Care Massage Therapy benefits may not duplicate Hospice or other State Plan benefits accessible to participants.

Limited to no more than 12 appointments per calendar year. This limit can be exceeded when medically necessary.

Certification/Provider Qualifications

Provider Agency Qualifications

Certified Home Health Agency (CHHA), Hospice Organization, Article 28 Clinic, and/or designated through the NYS Children's Provider Designation Review Team.

This requires agencies to have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners adhere to all Medicaid requirements in this Manual and in other applicable provider manuals, regulations, and statutes
- Provider agencies adhere to cultural competency guidelines
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served
- The provider agency ensures that staff receive Mandated Reporting training prior to service delivery

- The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable
- The provider agency ensures that any insurance required by the designating State agency is obtained and maintained
- The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency

Additional information and application for Children's HCBS can be found on the [DOH website](#).

Individual Staff Qualifications

- **Minimum Qualifications:**
 - Massage therapist currently licensed by the State of New York
 - An individual with a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Palliative Care	<ul style="list-style-type: none"> • Mandated Reporter 	<ul style="list-style-type: none"> • Prior to Service Delivery
	<ul style="list-style-type: none"> • Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	Training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix E.

Service Billing Details

Rate Code Description

The table below shows the show the rate code, CPT code, and modifier code combinations that will be required under Medicaid Managed Care. Providers will use these coding combinations to indicate to the MMCP that the claim is for a children/youth's service and is to be paid at the government rate. The procedure and

modifier code combinations must be adhered to by both provider and MMCP to ensure appropriate rate payment.

In acknowledgement of the need for checks against fraud and abuse, but to ensure a child/youth's access to services, service utilization in excess of the "soft" unit (i.e., annual, daily, dollar amount) limits must be based on medical necessity. Documentation of the medical necessity for extended durations must be kept on file in the child/youth's record. HCBS should be initially authorized for no more than six months at a time and based on each participant's unique needs. To exceed billing limits for children/youth enrolled in managed care, providers must contact the MMCP to receive guidance regarding the Plan's specific documentation requirements in these instances ; for children/youth enrolled in FFS, HCBS providers must maintain documentation from a licensed professional that outlines the need to exceed the service limit (e.g., copy of an assessment from a licensed professional; letter from a licensed professional that clearly describes the need for additional units of service, etc.).

In addition to requiring concurrent utilization review and authorization the MMCP may conduct post-payment administrative reviews to ensure services were provided appropriately.

Palliative Care – Massage Therapy					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Palliative Care - Massage Therapy	8018	97124	TJ	15 minutes	72 units/year

Palliative Care – Counseling and Support Services

Definition

Palliative Care is specialized medical care focused on providing relief from the symptoms and stress of a chronic medical, physical, or developmental condition or life-threatening illness. The goal of Palliative Care services is to improve quality of life for both the child/youth and the family. Palliative Care is provided by a specially trained team of doctors, nurses, social workers, and other specialists who work together with a child/youth's doctors to provide an extra layer of support. It is appropriate at any stage of a chronic medical, physical, or developmental condition or life-threatening illness and can be provided along with curative treatment.

Children/youth must meet LOC functional criteria and suffer from the symptoms and stress of a chronic medical, physical, or developmental condition or life-threatening illness.

Palliative Care Counseling and Support Services can be delivered:

1. To the participant with a chronic medical, physical, or developmental condition or life-threatening illness and the participant's identified family members prior to the passing of the participant,

AND/OR

2. To the participant's identified family after the passing of participant, if the HCBS provider's Service Plan and the care manager's plan of care (POC) denotes the service as outlined below.

The HHCM or C-YES will assist the family with obtaining a doctor's written order including justification for Counseling and Support Services from a Physician, Physician Assistant, Nurse Practitioner, Occupational Therapist, Physical Therapist or Psychiatrist. The written order is to be included with the child/youth's POC and made available to the MMCP as needed.

The Palliative Care Counseling and Support Services provider must conduct an **initial review** to determine the needs of the participant and their family. This review should be incorporated into the provider's Service Plan that outlines the frequency, scope, and duration of counseling to be provided *and* that service plan should be incorporated into the HCBS care management POC. For families to receive six (6) months of Counseling and Support Services after the passing of their child/youth the service must be included in the POC prior to the participant's passing. The family can also receive one (1) additional month of Health Home care management, and these needs should be incorporated in the POC.

Counseling and Support Services: Provide help for participants and their families to cope with grief related to the participant's chronic medical, physical, or developmental condition or life-threatening illness. Children/youth with a chronic medical, physical, or developmental condition or life-threatening illness and their families cope with grief and loss in a variety of ways and may need various kinds of support over time, including counseling, support groups, and other services. Counseling and Support Services can be provided to participants who are receiving services with a hospice care provider, if the services are not duplicative.

Further information regarding Counseling and Support Services, including the additional month of care management and post-mortem counseling and support can be found in the [Palliative Care – Bereavement Services and Health Home Care Management](#) policy.

Note: These services can be offered at any point after a Children's Waiver participant is diagnosed with a chronic medical, physical, or developmental condition or life-threatening illness.

Service Components

Counseling and Support Services – Help for participants and their families to cope with the participant's chronic medical, physical, or developmental condition or life-threatening illness and with grief / loss related to the participant's passing.

Modality

Counseling and Support Services 1:1; family eligible to participate

Setting

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community-based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

Palliative Care Counseling and Support Services benefits may not duplicate Hospice or other State Plan benefits accessible to participants.

Limited to the lesser of five appointments per month or 60 hours per calendar year.

Certification/Provider Qualifications

Provider Agency Qualifications

CHHA, Hospice Organization, Article 28 Clinic, and/or designated through the NYS Children's Provider Designation Review Team. This requires that agencies have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners adhere to all Medicaid requirements in this Manual and in other applicable provider manuals, regulations, and statutes
- Provider agencies adhere to cultural competency guidelines
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served
- The provider agency ensures that staff receive Mandated Reporting prior to service delivery
- The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable

- The provider agency ensures that any insurance required by the designating State agency is obtained and maintained
- The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency

Additional information and application for Children's HCBS can be found on the [DOH website](#).

Individual Staff Qualifications

- **Minimum Qualifications:**
 - An individual with a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care
 - Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Psychologist, Licensed Mental Health Counselor (LMHC), or Licensed Creative Arts Therapist (LCAT) that meet current NYS licensing guidelines
 - Student interns practicing within the scope of the New York State Education law and supervised by a licensed practitioner in that profession can deliver HCBS; student interns and limited permittees can treat Medicaid enrollees under the supervision of a licensed practitioners in that profession who must be enrolled as a Medicaid provider

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Palliative Care	<ul style="list-style-type: none"> • Mandated Reporter 	<ul style="list-style-type: none"> • Prior to Service Delivery
	<ul style="list-style-type: none"> • Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • Training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix E.

Service Billing Details

Rate Code Description

The tables below shows the show the rate code, CPT code, and modifier code combinations that will be required under Medicaid Managed Care. Providers will use

these coding combinations to indicate to the MMCP that the claim is for a children/youth's service and is to be paid at the government rate. The procedure and modifier code combinations must be adhered to by both provider and MMCP to ensure appropriate rate payment.

In acknowledgement of the need for checks against fraud and abuse, but to ensure a child/youth's access to services, service utilization in excess of the "soft" unit (i.e., annual, daily, dollar amount) limits must be based on medical necessity. Documentation of the medical necessity for extended durations must be kept on file in the child/youth's record. HCBS should be initially authorized for no more than six months at a time and based on each participant's unique needs. To exceed billing limits for children/youth enrolled in managed care, providers must contact the MMCP to receive guidance regarding the Plan's specific documentation requirements in these instances ; for children/youth enrolled in FFS, HCBS providers must maintain documentation from a licensed professional that outlines the need to exceed the service limit (e.g., copy of an assessment from a licensed professional; letter from a licensed professional that clearly describes the need for additional units of service, etc.).

In addition to requiring concurrent utilization review and authorization the MMCP may conduct post-payment administrative reviews to ensure services were provided appropriately.

Note: "Palliative Care - Counseling and Support Services" in the first table are provided by HCBS providers, and "Palliative Care – Bereavement Counseling Services" are provided by Health Homes, as outlined in the [Palliative Care – Bereavement Services and Health Home Care Management policy](#).

Palliative Care – Counseling and Support Services					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Palliative Care – Counseling and Support Services	8017	90832	TJ	30 minutes	Limited to the lesser of 10 units per month or 120 units per calendar year

Palliative Care - Bereavement Counseling Services					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Upstate Codes					

Bereavement Services - HH Low Acuity	7946	96156		Per assessment	1 unit/calendar year
Bereavement Services HH Medium Acuity	7947	96156		Per assessment	1 unit/calendar year
Bereavement Services - HH High Acuity	7948	96156		Per assessment	1 unit/calendar year
Downstate Codes					
Bereavement Services - HH Low Acuity	7949	96156		Per assessment	1 unit/calendar year
Bereavement Services - HH Low Acuity	7950	96156		Per assessment	1 unit/calendar year
Bereavement Services - HH Low Acuity	7951	96156		Per assessment	1 unit/calendar year
Bereavement Assessment/Counseling					
Bereavement - Assessment/Counseling	7952	96156		Bereavement Risk Assessment and up to six (6) months of Bereavement counseling	1 unit/ calendar year per member

Palliative Care – Pain and Symptom Management

Definition

Palliative Care is specialized medical care focused on providing relief from the symptoms and stress of a chronic medical, physical, or developmental condition or life-threatening illness. The goal of Palliative Care services is to improve quality of life for both the child/youth and the family. Palliative Care is provided by a specially trained team of doctors, nurses, social workers, and other specialists who work together with a child/youth's doctors to provide an extra layer of support. It is appropriate at any stage of a chronic medical, physical, or developmental condition and can be provided along with curative treatment.

Children/youth must meet LOC functional criteria and suffer from the symptoms and stress of chronic medical, physical, or developmental conditions.

The HHCM or C-YES will assist the family with obtaining a written order including justification for Pain and Symptom Management from a Physician. The written order is to be included with the child/youth's POC and made available to the MMCP as needed.

Pain and Symptom Management: Relief and/or control of the child/youth's suffering related to their chronic medical, physical, or developmental condition.

Pain and Symptom Management is an important part of aiding in providing relief from pain and symptoms and/or controlling pain, symptoms, and side effects related to chronic medical, physical, or developmental conditions or life-threatening illness a child/youth is enduring. This management is not only an important part of humanely caring for the child/youth's pain and suffering but helping the child/youth and family cope and preserve their quality of life at a difficult time.

Service Components

Pain and Symptom Management – Relief and/or control of the child/youth's suffering related to their chronic medical, physical, or developmental condition.

Modality

- **Pain and Symptom Management** – 1:1

Setting

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community-based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

Palliative Care Pain and Symptom Management benefits may not duplicate Hospice or other State Plan benefits accessible to participants.

Certification/Provider Qualifications

Provider Agency Qualifications

Certified Home Health Agency (CHHA), Hospice Organization, or Article 28 Clinic and designated through the NYS Children's Provider Designation Review Team.

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners adhere to all Medicaid requirements in this Manual and in other applicable provider manuals, regulations, and statutes
- Provider agencies adhere to cultural competency guidelines
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served
- The provider agency ensures that staff receive Mandated Reporting training prior to service delivery
- The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable
- The provider agency ensures that any insurance required by the designating State agency is obtained and maintained
- The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency

Additional information and application for Children's HCBS can be found on the [DOH website](#).

Individual Staff Qualifications

- **Minimum Qualifications:**
 - An individual with a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care
 - Pediatrician or Family Medicine Physician board certified in Pediatrics or Family Medicine licensed by the State of New York; Nurse Practitioner licensed by the State of New York (Pain and Symptom Management); or Registered Nurse licensed by the State of New York under the direct supervision of a pediatrician or medical physician, board certified in Pediatrics.

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Palliative Care	<ul style="list-style-type: none"> • Mandated Reporter 	<ul style="list-style-type: none"> • Prior to Service Delivery
	<ul style="list-style-type: none"> • Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention 	<ul style="list-style-type: none"> • Training must be completed within six (6) months of hire date.

Service Type	Trainings Required	Requirement Completion Timeframe
	<ul style="list-style-type: none"> Domestic Violence Signs and Basic Interventions Trauma Informed Care 	

Additional information regarding training requirements can be found in Appendix E.

Service Billing Details

Rate Code Description

The below table shows the show the rate code, CPT code, and modifier code combinations that will be required under Medicaid Managed Care. Providers will use these coding combinations to indicate to the MMCP that the claim is for a children/youth's service and is to be paid at the government rate. The procedure and modifier code combinations must be adhered to by both provider and MMCP to ensure appropriate rate payment.

In acknowledgement of the need for checks against fraud and abuse, but to ensure a child/youth's access to services, service utilization in excess of the "soft" unit (i.e., annual, daily, dollar amount) limits must be based on medical necessity. Documentation of the medical necessity for extended durations must be kept on file in the child/youth's record. HCBS should be initially authorized for no more than six months at a time and based on each participant's unique needs. To exceed billing limits for children/youth enrolled in managed care, providers must contact the MMCP to receive guidance regarding the Plan's specific documentation requirements in these instances ; for children/youth enrolled in FFS, HCBS providers must maintain documentation from a licensed professional that outlines the need to exceed the service limit (e.g., copy of an assessment from a licensed professional; letter from a licensed professional that clearly describes the need for additional units of service, etc.).

In addition to requiring concurrent utilization review and authorization, the MMCP may conduct post-payment administrative reviews to ensure services were provided appropriately.

Palliative Care – Pain and Symptom Management					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Palliative Care - Pain and Symptom Management	8016	99347	TJ	15 minutes	No limit, as required by child/youth's physician order

Adaptive and Assistive Technology

Definition

Adaptive and Assistive Technology (AT) provides technological aids and devices identified within the child/youth's POC which enable the accomplishment of daily living tasks that are necessary to support the health, welfare, and safety of the child/youth.

Service Components

Adaptive and Assistive Technology includes but is not limited to:

- Positioning devices
- Mobility devices
- Augmentative Communication devices
- Computer Accessibility devices
- Assistive Demotics/Home Automation devices
- Standing boards/frames and therapeutic equipment for the purpose of maintaining or improving the participant's strength, mobility, or flexibility to perform activities of daily living
- Adaptive switches/devices
- Meal preparation and eating aids/devices/appliances
- Specially adapted locks
- Motorized wheelchairs
- Guide dogs, hearing dogs, service dogs (as defined in New York Civil Rights Law Article 47-b(4)) (for additional guidance regarding service dogs, please refer to Appendix F)
- Electronic, wireless, solar-powered, or other energy powered devices that demonstrate to the satisfaction of the commissioner, or designee, that the device(s) will significantly enable the participant to live, work, or meaningfully participate in the community with less reliance on paid staff supervision or assistance
 - Such devices may include computers, observation cameras, sensors, telecommunication screens, and/or telephones and/or other telecare support services/systems that enable the participant to interact with remote staff to ensure health and safety
 - Such devices cannot be used for surveillance, but to support the person to live with greater independence including devices to assist with medication administration, including tele-care devices that prompt, teach, or otherwise assist the participant to independently self-administer medication routinely, portable generators necessary to support equipment, or devices needed for the health or safety of the person including stretcher stations

Adaptive and Assistive Technology Services include:

- Evaluation of the adaptive and assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate adaptive and assistive technology and appropriate services to the participant in the customary environment of the participant

- Services consisting of purchasing, leasing, or otherwise providing for the acquisition of adaptive and assistive technology devices for the participant
- Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing adaptive and assistive technology devices
- Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant
- Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of the participant

Modality

The HHCM/C-YES will coordinate requests for AT with the LDSS in conjunction with DOH for children/youth enrolled in Fee-for-Service Medicaid. The HHCM/C-YES will coordinate requests for AT with the Medicaid Managed Care Plan for children/youth enrolled in a MMCP.

Limitations/Exclusions

The Adaptive and Assistive Technology available through the HCBS authorities cannot duplicate equipment and/or technology otherwise available through the Medicaid State Plan under 1905(a) of the Social Security Act or other federal/state funding streams. Equipment must be beyond the scope of Durable Medical Equipment (DME). DME is a SPA service and needs to be pursued first, if the need meets the DME requirements. Care Managers can consult with NYS DOH prior to submitting the request for DME.

Refer to the [DME Manual](#) (under 'Fee Schedule') for further information.

Adaptive and assistive devices are expected to be a one-time only purchase. Replacements, repairs, upgrades, and/or enhancements made to existing equipment will be paid if documented as a necessity and approved by the State or its designee. Ongoing monitoring associated with telecare support services or other approved systems authorized under this definition may be provided, if necessary, for health and safety and documented to the satisfaction of the State or designee. The HHCM, C-YES, or MMCP will ensure, that where appropriate, justification from physicians or other specialists or clinicians has been obtained.

Warranties, repairs, and/or maintenance on adaptive and assistive technology only when most cost effective and efficient means to meet the need and are not available through the Medicaid State Plan 1905(a) or third-party resources.

Cost Limits

All Adaptive and Assistive Technology costs require prior approval from the LDSS in conjunction with DOH or the MMCP. Adaptive and Assistive Technology is subject to a \$15,000 per calendar year soft cap. The State or its designee may consider exceptions

when medically necessary, including but not limited to a significant change in the child's needs or capabilities.

Certification/ Provider Qualifications

For Adaptive and Assistive Technology, the LDSS (for FFS enrollees) or MMCP (for managed care enrollees) is the provider of record for billing purposes using the standard bidding process.

The HHCM/C-YES will assist in determining the need for the service, identifying the expected benefit to the child/youth, obtaining a physician's order, obtaining the clinical justification and/or scope of the work, securing bids, and facilitating the completion of the Final Cost Form.

The LDSS or MMCP secures a vendor qualified to complete the required work. For FFS enrollees, standard provisions of the NYS Finance Law and procurement policies must be followed to ensure that vendors are qualified, and that State-required bidding procedures have been followed. MMCPs are not required to obtain bids for Adaptive and Assistive Technology projects. Final payment to vendors is provided once project is verified as complete and in compliance with approved project scope.

LDSS or MMCP staff verify the qualifications of the Adaptive and Assistive Technology vendor:

- Must be familiar with the Adaptive and Assistive Technology policies permitted in the waiver program as described in this Manual; the LDSS or MMCP should supply the evaluator with a copy of both prior to initiation of the evaluation
- Must be able to communicate well with all parties involved with the purchase of the equipment and any training needed (e.g., consumers, contractors, and local government officials)
- Must be able to clearly describe in writing, and by design, the proposed purchase
- Must have knowledge of assistive technology and specific adaptive equipment appropriate for the child/youth's needs

LDSS, in conjunction with DOH or the MMCP will determine the most cost-effective service that will meet the child/youth's needs.

For further information regarding assessing need, service authorization, service delivery, and payment, including process flows refer to the following **Adaptive and Assistive Technology Resources and Forms**:

- [Parent Info Sheet- Adaptive and Assistive Technology](#)
- [Guidelines for Authorizing Adaptive and Assistive Technology](#)
- [Pre-project Evaluation Payment Request Form](#)
- [Description and Cost Projection Form](#)
- [Notice of Decision to Authorize or Deny Adaptive and Assistive Technology](#)
- [Final Cost Form](#)

Service Billing Details

FFS Billing

Some providers of AT will require partial payment to purchase materials, technology, and/or equipment. In addition, the evaluator/assessor invoice may have to be paid prior to completion of the modification/adaptation request. To address these potential barriers, the NYS DOH has established a Special Project Voucher (SPV) Fund and a process that will eliminate the need for the LDSS to front funds to non-Medicaid enrolled providers in advance of receiving Medicaid reimbursement for LDSS-authorized services.

When the LDSS requires upfront funds for an AT service, the LDSS must submit the *Pre-project Evaluation Payment Request Form* and/or the *Description and Cost Projection Form*, as appropriate, with all supporting documents to the NYS DOH. NYS DOH's Children's Waiver staff will process the request for SPV funds, including requesting that a check be issued to the County Treasurer at the LDSS. Please note, the check will be issued from the Office of Temporary and Disability Assistance (OTDA). If the request is not approved, the LDSS will be so notified. If additional information is needed, the disbursement may be delayed pending submission of the additional information.

MMCP Billing

Adaptive and Assistive Technology will be billed using 837P by the Plan when submitting the encounter to DOH.

The table below shows the rate code, CPT code, and modifier code combination that will be required under Medicaid Managed Care. The procedure and modifier code combinations must be adhered to by the MMCP to ensure appropriate rate payment.

Adaptive and Assistive Technology					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Adaptive and Assistive Technology	8037	T2028	HA	\$1.00	\$15,000 per calendar year

Adaptive and Assistive Technology	8038	T2028	HA, V1	\$10.00	\$15,000 per calendar year
Adaptive and Assistive Technology	8039	T2028	HA, V2	\$100.00	\$15,000 per calendar year
Adaptive and Assistive Technology	8040	T2028	HA, V3	\$1,000.00	\$15,000 per calendar year

Vehicle Modifications

Definition

Vehicle Modifications (VMods) provide physical adaptations to the primary vehicle of the enrolled child/youth which, per the child/youth's POC, are identified as necessary to support the health, welfare, and safety of the child/youth or that enable the child/youth to function with greater independence.

Service Components

Modifications include but are not limited to:

- Portable electric/hydraulic and manual lift
- Ramps
- Foot controls
- Wheelchair lock downs/wheelchair floor
- Deep dish steering wheel
- Spinner knobs
- Hand controls
- Parking brake extension
- Replacement of roof with fiberglass top
- Floor cut outs
- Extension of steering wheel column
- Raised door
- Repositioning of seats
- Dashboard adaptations
- Other ancillary equipment or modifications necessary to guarantee full access to, and safety in, a motor vehicle

The LDSS (for FFS enrollees) or MMCP (for managed care enrollees) secures a contractor and/or evaluator qualified to complete the required work. In the case of Vehicle Modifications, the evaluators and modifiers are approved by the National Mobility Equipment Dealers Association (NMEDA). Activities include but are not limited to; determining the need for the service, the safety of the proposed modification, its expected benefit to the child/youth, and the most cost-effective approach to fulfill the child/youth's need.

In FFS, the work is done by a contractor who is selected by the LDSS in conjunction with DOH through a standard bid process, following the rules established by the Office of the State Comptroller. Standard provisions of the NYS Finance Law and procurement policies must be followed to ensure that contractors are qualified and that State-required bidding procedures have been followed. Final payment to vendors is provided once project is verified as complete and in compliance with approved project scope.

In managed care, the Plan is the payer and may contract with an approved network provider for the service. MMCPs are not required to obtain bids for vehicle modification projects. Services are only billed to the MMCP once the contract work is verified as complete and the amount billed is equal to the contract value of the approved scope.

Note: This service does not duplicate other services available through the New York Medicaid State Plan. All services require prior authorization by the MMCP or the LDSS in conjunction with DOH.

Modality

The HHCM/C-YES will coordinate requests for VMods with the LDSS in conjunction with DOH for children/youth enrolled in Fee-for-Service Medicaid. The HHCM/C-YES will coordinate requests for VMods with the Medicaid Managed Care Plan for children/youth enrolled in a MMCP.

Limitations/Exclusions

Other exclusions include the purchase, installation, and/or maintenance of items such as cellular phones, global positioning/tracking devices, or other mobile communication devices; repair or replacement of modified equipment damaged or destroyed in an accident; alarm systems; auto loan payments; insurance coverage; costs related to obtaining a driver's license, title/registration, license plates, emergency road service, or rental vehicles when a vehicle modification is in process.

Repair & Replacement of Modification

In most instances a specific type of Vehicle Modification is a one-time benefit to motor vehicles used by the child/youth. However, in reasonable circumstances determined and approved by the State, a second modification may be considered for funding if the current modifications are in need of repair, worn-out, or unsafe. Replacements, repairs, upgrades, or enhancements made to existing equipment will be paid if documented as a necessity. In addition, when the modification must be replaced or repaired, a depreciation schedule will be used to determine the limit of the amount to be applied to the cost.

Vehicle Modifications are limited to the primary means of transportation for the child/youth. The vehicle may be owned by the child/youth or by a family member or non-relative who provides primary, consistent, and ongoing transportation for the child/youth. All equipment and technology used for entertainment is prohibited.

Modification Limits

Only those services not reimbursable under the Medicaid State Plan under 1905(a) of the Social Security Act, or other federal/state funding streams will be reimbursable under the HCBS Waiver.

Contracts for Vehicle Modifications may not exceed \$25,000 per calendar year without prior approval from DOH or the MMCP. The State may consider exceptions when medically necessary, including but not limited to a significant change in the child's needs or capabilities.

Certification/Provider Qualifications

Modification Contractor/Craftsman with licensure appropriate to the trade.

LDSS or MMCP staff verify the qualifications of vehicle modification providers who must present the following knowledge and skills:

- Must be familiar with the Vehicle Modification policies permitted in the waiver program as described in State guidance; the LDSS/HRA/MMCP should supply the evaluator with a copy of both prior to initiation of the evaluation
- Must be able to communicate well with all parties involved with the development of Vehicle Modifications (e.g., consumers, contractors, and local government officials)
- Must be able to clearly describe in writing, and by design, the proposed vehicle modification
- Must know and be able to apply the New York State Building Code, Current Accessibility Standards, and the Federal Accessibility Guidelines found in the Fair Housing Amendment Act (as relevant to any vehicle modification)
- Must have knowledge of assistive technology and specific adaptive equipment appropriate for the child/youth's needs
- Must have skill in design/drafting in order to clearly describe the proposed modification
- Must be able to complete all components of an On-Site Evaluation

Contractors performing any adaptation for a child/youth in the waiver program is required to:

- Be bonded
- Maintain adequate and appropriate licensure
- Maintain vehicle modification provider certification from NMEDA

Provider qualifications are verified at the beginning of the Vehicle Modification project by the LDSS/MMCP.

Vehicle Modification Resources and Forms:

- [Parent Info Sheet- Vehicle Modifications](#)
- [Guidelines for Authorizing Vehicle Modifications](#)
- [Pre-project Evaluation Payment Request Form](#)
- [Description and Cost Projection Form](#)
- [Notice of Decision to Authorize or Deny Vehicle Modifications](#)
- [Final Cost Form](#)

Service Billing Details

FFS Billing

Most providers of VMods will require partial payment to purchase materials, technology, and/or equipment. In addition, the evaluator/assessor invoice may have to be paid prior to completion of the modification. To address these potential barriers, the NYS DOH has established a Special Project Voucher (SPV) Fund and a process that will eliminate the need for the LDSS to front funds to non-Medicaid enrolled providers in advance of receiving Medicaid reimbursement for LDSS-authorized services.

When the LDSS requires upfront funds for a VMod service, the LDSS must submit the *Pre-project Evaluation Payment Request Form* and/or the *Description and Cost Projection Form*, as appropriate, with all supporting documents to the NYS DOH. NYS DOH's Children's Waiver staff will process the request for SPV funds, including requesting that a check be issued to the County Treasurer at the LDSS. Please note, the check will be issued from the Office of Temporary and Disability Assistance (OTDA). If the request is not approved, the LDSS will be so notified. If additional information is needed, the disbursement may be delayed pending submission of the additional information.

MMCP Billing

Plans will use 837I encounter format when billing DOH for VMod services.

The table below shows the rate code, CPT code, and modifier code combinations that will be required under Medicaid Managed Care. The procedure and modifier code combinations must be adhered to by the MMCP to ensure appropriate rate payment.

Vehicle Modifications					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Vehicle Modifications	8041	T2039	HA	\$1.00	\$25,000 per calendar year
Vehicle Modifications	8042	T2039	HA, V1	\$10.00	\$25,000 per calendar year

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Vehicle Modifications	8043	T2039	HA, V2	\$100.00	\$25,000 per calendar year
Vehicle Modifications	8044	T2039	HA, V3	\$1,000.00	\$25,000 per calendar year

Environmental Modifications

Definition

Environmental Modifications (EMods) provide internal and external physical adaptations to the primary residence of the enrolled child/youth which, per the child/youth's POC, are identified as necessary to support the health, welfare, and safety of the child/youth or that enable the child/youth to function with greater independence in the home and without which the child/youth would require an institutional and/or more restrictive living setting.

Service Components

Modifications include but are not limited to:

- Installation of ramps, handrails, and grab-bars
- Widening of doorways (but not hallways)
- Modifications of bathroom facilities
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies needed for the welfare of the recipient
- Lifts and related equipment
- Elevators when no feasible alternative is available
- Automatic or manual door openers/bells
- Modifications of the kitchen necessary for the participant to function more independently in his/her home
- Medically necessary air conditioning
- Braille identification systems
- Tactile orientation systems
- Bed shaker alarm devices
- Strobe light smoke detection and alarm devices
- Small area driveway paving for wheel-chair entrance/egress from van to home

Safe environment modifications for behaviorally challenged participants require the prior review of a behavioral specialist and include window protections, reinforcement of walls, durable wall finishes, open-door signal devices, fencing, video monitoring systems, and shatter-proof shower doors. These may also include future technology devices that allow the participant to live more safely and independently to avoid possible institutional placement or placement in a more restrictive living environment, which are available at a reasonable cost in comparison to living in a more restrictive residential setting.

The scope of Environmental Modifications will also include necessary assessments to determine the types of modifications needed.

Note: This service does not duplicate other services available through the New York Medicaid State Plan. All services require prior authorization by the LDSS in conjunction with DOH if exceeding established limits or MMCP.

Modality

The HHCM/C-YES will coordinate requests for EMods with the LDSS in conjunction with DOH for children/youth enrolled in Fee-for-Service Medicaid. The HHCM/C-YES will coordinate requests for EMods with the Medicaid Managed Care Plan for children/youth enrolled in a MMCP.

Limitations/Exclusions

Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the child/youth. Adaptations that add to the total square footage of the home's footprint are excluded from this benefit except when necessary to complete an adaptation (e.g. in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Also excluded are pools and hot tubs and associated modifications for entering or exiting the pool or hot tub.

Repair & Replacement of Modification

In most instances, a specific type of Environmental Modification is a one-time benefit. However, in reasonable circumstances determined and approved by the State, a second modification may be considered for funding as follows: if a person moves to another home; if the current modifications are in need of repair, worn-out, or unsafe; or if a participant wishes to spend considerable time with a non-cohabitating parent in their home and such modifications are required to ensure health and safety during these periods.

State policy places certain limitations on environmental modifications requested when the home/apartment is a leased space, including property owner sign-off on the modification and limitations on federal/state liability for the cost of removal/replacement/repair of items in public spaces of rental properties.

Modification Limits

Only those services not reimbursable under the Medicaid State Plan under 1905(a) of the Social Security Act, or other federal/state funding streams will be reimbursable under the HCBS Waiver.

All Environmental Modifications require prior approval from the LDSS in conjunction with DOH or the MMCP. For Environmental Modifications, the LDSS or MMCP is the provider of record for billing purposes. Environmental Modifications have a \$25,000 per calendar year soft cap. The State may consider exceptions when medically necessary, including but not limited to a significant change in the child/youth's needs or capabilities.

Note: This service does not duplicate other services available through the New York Medicaid State Plan. All services require prior authorization by the LDSS in conjunction with DOH if exceeding established limits or MMCP.

Certification/Provider Qualifications

Environmental Modification Contractor/Craftsman with licensure appropriate to trade.

LDSS or MMCP staff verify the qualifications of home modification providers present the following knowledge and skills:

- Must be familiar with the home adaptation policies permitted in the waiver program as described in state guidance; the LDSS/HRA/MMCP should supply the evaluator with a copy of both prior to initiation of the evaluation
- Must be able to communicate well with all parties involved with the development of home adaptations (e.g., consumers, contractors, and local government officials)
- Must be able to clearly describe in writing, and by design, the proposed home adaptation
- Must know and be able to apply the New York State Building Code, Current Accessibility Standards, and the Federal Accessibility Guidelines found in the Fair Housing Amendment Act (as applicable to the home modification)
- Must have knowledge of assistive technology and specific adaptive equipment appropriate for the child/youth's needs
- Must have skill in design/drafting in order to clearly describe the proposed modification
- Must be able to complete all components of an on-site evaluation

Contractors performing any adaptation for a child/youth in the waiver program are required to:

- Be bonded
- Maintain adequate and appropriate licensure
- Obtain any and all permits required by state and local municipality codes for the modification
- Agree that before final payment is made the contractor must show that the local municipal branch of government that issued the initial permit has inspected the work

Provider qualifications are verified at the beginning of the Environmental Modification contract by the LDSS/MMCP.

Environmental Modification Resources and Forms:

- [Parent Info Sheet- Environmental Modifications](#)
- [Guidelines for Authorizing Environmental Modifications](#)
- [Guidance on Environmental Modifications to Support Behaviorally Health Challenged Members](#)
- [Pre-project Evaluation Payment Request Form](#)
- [Description and Cost Projection Form](#)
- [Notice of Decision to Authorize or Deny Environmental Modifications](#)
- [Final Cost Form](#)

Service Billing Details

FFS Billing

Most providers of EModswill require partial payment to purchase materials, technology, and/or equipment. In addition, the evaluator/assessor invoice may have to be paid prior to completion of the modification. To address these potential barriers, the NYS DOH has established a Special Project Voucher (SPV) Fund and a process that will eliminate the need for the LDSS to front funds to non-Medicaid enrolled providers in advance of receiving Medicaid reimbursement for LDSS-authorized services.

When the LDSS requires upfront funds for an EMod service, the LDSS must submit the *Pre-project Evaluation Payment Request Form* and/or the *Description and Cost Projection Form* with all supporting documents to the NYS DOH. NYS DOH's Children's Waiver staff will process the request for SPV funds, including requesting that a check be issued to the County Treasurer at the LDSS. Please note, the check will be issued from the Office of Temporary and Disability Assistance (OTDA). If the request is not approved, the LDSS will be so notified. If additional information is needed, the disbursement may be delayed pending submission of the additional information.

MMCP Billing

Plans will use 837I encounter format when billing DOH for EMod services.

The table below shows the rate code, CPT code, and modifier code combinations that will be required under Medicaid Managed Care. The procedure and modifier code combinations must be adhered to by the MMCP to ensure appropriate rate payment.

Environmental Modifications					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Environmental Modifications	8032	S5165	HA	\$1.00	\$25,000 per calendar year
Environmental Modifications	8034	S5165	HA, V1	\$10.00	\$25,000 per calendar year

Environmental Modifications	8035	S5165	HA, V2	\$100.00	\$25,000 per calendar year
Environmental Modifications	8036	S5165	HA, V3	\$1,000.00	\$25,000 per year calendar

Non-Medical Transportation

Definition

Non-Medical Transportation services are offered, in addition to any medical transportation furnished under the 42 CFR 440.17(a) in the State Plan. Non-Medical Transportation services are available for individuals to access authorized HCBS and destinations that are related to a goal included on the child/youth's POC.

Service Components

Examples where this service may be requested include transportation to: HCBS that a child/youth was determined eligible to receive, a job interview, college fair, a wellness seminar, a GED preparatory class, etc. This service will be provided to meet the child/youth's needs as determined by an assessment performed in accordance with the State's requirements and as outlined in the child/youth's POC.

The care manager must document a need for transportation to support an individual's identified goals. The HHCM will include justification for this service within the Person-Centered POC. For individuals not enrolled in a HH, the Independent Entity or MMCP will be responsible for completing documentation of which goals in an individual's POC to which the trips will be tied. For each participant utilizing Non-Medical Transportation, the Transportation Manager will provide a monthly report of authorized trips to the State.

Limitations/Exclusions

Generally, the same rules used to determine reimbursement of trips to medical appointments should be followed when considering reimbursement of non-medical trips for eligible participants. Only those services not reimbursable under the CFCO State Medicaid Plan will be reimbursable under the HCBS Waiver.

The following guidelines apply to Non-Medical Transportation:

- Transportation must be tied to a goal in the POC
- Transportation is available for a specified duration
- Individuals receiving residential services are ineligible for Non-Medical Transportation
- Use transportation available free of charge
- Use the medically appropriate mode of transportation
- Travel within the common marketing area
- When possible, trips should be combined
- Justify need for travel outside the common marketing area

Vouchers submitted for personal vehicle mileage reimbursement must be submitted within 90 days of the date of service. Only when there are extenuating circumstances, will DOH allow payment for trips that are submitted after the 90-day time period. These requests will be considered on a case-by-case basis provided valid justification is given.

Reimbursement for travel can be denied when the destination does not support the participant's integration into the community.

A participant's POC outlines the general parameters of the child/youth's Non-Medical Transportation needs. However, these needs can change or be amended based upon the participant's stated goals and/or successful ongoing integration into the community.

Certification/Provider Qualifications

Agencies interested in providing Non-Medical Transportation must be enrolled in the FFS program as a current Medicaid Transportation Provider.

Please see the following links on information on Medicaid Transportation:

- [Transportation Provider Manuals](#)
- [Transportation Provider Enrollment Application](#)

Roles Related to a Participant's Access to Non-Medical Transportation

The following roles and guidelines serve to inform the HHCM, MMCP, and the Transportation Manager of the procedures and rules surrounding an eligible participant's access to the Non-Medical Transportation benefit.

HHCM Roles

HHCMs are responsible for conducting and developing the Person-Centered POC. If the care manager determines there is a need for transportation to support an individual's identified goals, the HHCM will include justification for this service within the Person-Centered POC. The HHCMs will complete the [DOH POC Grid for Non-Medical Transportation for Children's HCBS](#) (Grid) with all known information. It is possible that the complete trip destination details may not be known (e.g. exact appointment time and date). This information can be provided by the enrollee to the Transportation Manager upon request of transportation.

The CMA should at a minimum list the goal from the POC; specific activity, support, or task; provider of services (if applicable); start and end date. After completing the POC and the Grid, the HHCM will send it to the MMCP. If the child/youth is not yet enrolled in a plan, the HHCM will send the Grid directly to Department of Health's Medicaid Transportation Manager for review.

Medicaid Managed Care Plan Roles

The MMCP is responsible for approving the Person-Centered POC and for forwarding the completed Grid to DOH's Medicaid Transportation Manager.

For individuals not enrolled in a HH, the MMCP will be responsible for completing the Grid based on the individual's POC and forwarding to the Transportation Manager. The Grid will include documentation for Non-Medical Transportation including documentation of which goals in an individual's POC the trips will be tied to.

The **DOH POC Grid for Non-Medical Transportation for Children's HCBS** is completed by the MMCP based on the participant's POC and includes the following information:

- Participant information
- HCBS provider information
- Non-Medical Transportation service requested
- Supporting information includes:
 - Goal from the POC
 - HCBS or specific activity/support/task
 - Mode of transportation service needed
 - Trip destination/location
 - Start date/end date
 - Frequency

The MMCP will forward the completed Grid to the Transportation Manager any time there are changes to the Grid.

Transportation Manager Roles

The Transportation Manager is responsible for authorizing transportation services in accordance with Medicaid policy, by approved Medicaid Transportation providers, and as supported on the MMCP-provided Grid. Once the Grid is received from the MMCP, the Transportation Manager should assume that the MMCP has reviewed and approved the Non-Medical Transportation included in the individual's POC and that trips included in the Grid are appropriate. The Transportation Manager is responsible for ensuring adherence to the guidelines below for Non-Medical Transportation, which include assigning the most medically appropriate, cost-effective mode of transportation. Enrollees have freedom of choice regarding the transportation provider within the assigned mode (e.g. ambulette, taxi, public transportation, etc.).

Contact Information for Transportation Managers

NYC & Upstate: Medical Answering Services (MAS)

- [Website](#)
- [Forms & Resources for Enrollees](#)
- [Physician Attestation for Mileage Reimbursement Individual Appointments](#)

Fax number for submitting all forms: (315) 299-2786

Secure email: Harp-info@medanswering.com

(When sending completed Grids: "Attn: Non-Medical Transportation for Children's Home and Community Based Services (HCBS)")

Long Island: LogistiCare Solutions, LLC

- [Website](#)
- [Medicaid Transformation Information on Website](#)

Fax number for submitting mileage reimbursement forms: (866) 528-0462
(When sending completed Grids: *Attn: Non-Medical Transportation for Children's Home and Community Based Services (HCBS)*)

Additional Contact Information:

NYS Department of Health Transportation Unit: medtrans@health.ny.gov

NYS Office of Mental Health: omh.sm.co.HCBS-Application@omh.ny.gov

Service Billing Details

Non-Medical Transportation will be paid fee-for-service for eligible children/youth, regardless of whether the child/youth is enrolled in Medicaid Managed Care. Please refer to the [Medicaid Transportation Guidelines](#) for more details.

APPENDICES

Appendix A: Glossary of Key Terms

Care Team or Multi-disciplinary Team: Are the providers, identified family supports, family members, managed care plan and other individuals or entities that the child/youth or family identified to be involved in the care coordination and service provision development.

Child/Youth: Throughout this document, the term “child/youth” or “children/youth” refers to a child/youth under age 21.

Children and Youth Evaluation Service (C-YES): C-YES is the State-designated Independent Entity which conducts HCBS/LOC eligibility determinations and provides Medicaid application assistance for children who are eligible for HCBS and not yet enrolled in Medicaid. C-YES also develops an HCBS POC, refers eligible children for HCBS, and monitors access to care for children who opt out of HH care management.

Collateral Contact: Family members, caregivers, and other stakeholders identified on the child/youth's Plan of Care.

Cultural Competency: Defined as attributes of a behavioral healthcare organization that describe the set of congruent behaviors, attitudes, skills, policies, and procedures that are promoted and endorsed to enable caregivers at all levels of the organization to work effectively and efficiently with persons and communities of all cultural backgrounds. An important element of cultural competence is the capacity to overcome structural barriers in healthcare delivery that sustain health and healthcare disparities across cultural groups.

Developmental Disability: Section 1.03(22) of the New York State Mental Hygiene Law is the legal base for eligibility determination and defines Developmental Disability as: A disability of a person that: (a)(1) Is attributable to an intellectual disability cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, Prader-Willi syndrome or autism; (2) Is attributable to any other condition of a person found to be closely related to an intellectual disability because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of intellectually disabled persons or requires treatment and services similar to those required for such persons; or (3) Is attributable to dyslexia resulting from a disability described in (1) or (2); (b) Originates before such person attains age twenty-two; (c) Has continued or can be expected to continue indefinitely; and (d) Constitutes a substantial handicap to such person's ability to function normally in society.

Discharge: Describes when a participant will no longer receive HCBS. In some cases, a child/youth may be released from specific HCBS that no longer meets the child/youth's goals but may remain in receipt of additional HCBS.

Disenrollment: Describes when a participant is being released from the Children's Waiver.

Duration: Describes how long the service will be delivered to the child/youth and/or family. The duration of the service should correspond to the abilities of the child/family and be reflective of the billing unit identified by service.

Evidence-Based: Services must utilize evidence-based practices where appropriate and provide or enable continuing education activities to promote uptake of these practices.

Family: Family is defined as the primary caregiving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the child/youth, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home.

"Family of One": A commonly used phrase to describe a child/youth that becomes eligible for Medicaid through use of institutional eligibility rules for certain medically needy individuals. These rules allow a budgeting methodology for children/youth to meet Medicaid financial eligibility criteria as a "family of one," using the child/youth's own income and disregarding parental income.

Frequency: Outlines how often the service will be offered to the child/youth and/or family. Services may be delivered on a weekly, biweekly or monthly basis, according to the needs of the child/youth and family.

HCBS/LOC Eligibility Determination: A tiered assessment where multiple factors must be met for child/youth's HCBS/LOC eligibility to be determined. To access Children's HCBS, a child/youth must meet target population, risk factors, and functional criteria as described in the Children's Waiver. The HCBS/LOC Eligibility Determination is housed within the Uniform Assessment System (UAS).

Health Home Serving Children (HHSC): A State-designated program that provides comprehensive care management, care coordination and health promotion, comprehensive transitional care, patient and family support, referral to community supports, and the use of Health Information Technology (HIT) to link services for children/youth who meet HH eligibility criteria (i.e. 1) must be enrolled in Medicaid; 2) must have two or more chronic conditions or one single qualifying chronic condition of HIV/AIDS, Serious Mental Illness, Serious Emotional Disturbance, or Complex Trauma).

Home or Community Setting: Home setting or community setting means the setting in which children/youth primarily reside or spend time, as long as it is not a hospital nursing facility, Intermediate Care Facility (ICF), or psychiatric nursing facility. Note: this is distinguished from a Home *and* Community based setting.

Licensed Practitioner of the Healing Arts: An individual professional who is a Licensed psychoanalyst, Licensed psychologist, Licensed Clinical Social Worker, Nurse Practitioner, Physician, Physician Assistant or Psychologist and practicing within the scope of their State license. LPHAs who sign off on the HCBS Attestation form must be able to diagnose within their scope of practice.⁴

- a. **Licensed Psychologist** is an individual who is currently licensed and currently registered as a psychologist by the New York State Education Department from the New York State Education Department and who possesses a doctoral degree in psychology.
- b. **Licensed Clinical Social Worker (LCSW)** is an individual who is currently licensed and registered as a Clinical Social Worker by the New York State Education Department.
- c. **Nurse Practitioner** is an individual who is currently certified as a nurse practitioner by the New York State Education Department.
- d. **Physician** is an individual who is licensed and currently registered as a physician by the New York State Education Department.
- e. **Physician Assistant** is an individual who is currently registered as a physician assistant by the New York State Education Department.
- f. **Psychiatrist** is an individual who is licensed and currently registered to practice medicine in New York State, who (i) is a diplomat of the American Board of Psychiatry and Neurology or is eligible to be certified by that Board, or (ii) is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by that Board.

The following Licensed Practitioners, if under the supervision of an LPHA (as defined above) are also eligible to complete the HCBS LPHA Attestation form:

- a. **Licensed Psychoanalyst** is an individual who is currently licensed and currently registered as a psychoanalyst by the New York State Education Department.
- b. **Licensed Marriage & Family Therapist (LMFT)** is an individual who is licensed and currently registered as a marriage and family therapist by the New York State Education Department.

⁴ The LPHA Attestation form is no longer required for the Target Populations of Medically Fragile (MF) or Developmental Disability who are Medically Fragile (DD/MF).

- c. **Licensed Mental Health Counselor (LMHC)** is an individual who is licensed and currently registered as a mental health counselor by the New York State Education Department.
- d. **Licensed Creative Arts Therapist (LCAT)** is an individual who is licensed and currently registered as a Creative Arts Therapist by the New York State Education Department possesses a creative arts therapist permit from the New York State Education Department.
- e. **Registered Professional Nurse** is an individual who is licensed and currently registered as a registered professional nurse by the New York State Education Department.
- g. **Licensed Master Social Worker (LMSW)** is an individual who is either currently registered as a Licensed Master Social Worker (LMSW) by the New York State Education Department.

Institutionalization: Admission to a hospital (medical or psychiatric), RTF, ICF/IID or nursing facility.

Integrated: Success for children/youth requires both integrated and effective treatment. Initial and on-going collaboration between providers and natural supports is fundamental to enhancing resiliency, meeting the imperatives of developmental stages, and promoting wellness for each child/youth and their family.

Licensed Occupational Therapist: An individual who is licensed and currently registered as an Occupational Therapist by the New York State Education Department that assists people across the lifespan to do the things they want and need to do through the therapeutic use of daily activities (occupations). Common occupational therapy interventions include helping children with disabilities to participate fully in school and social situations, helping people recovering from injury to regain skills, and provide customized interventions to improve the person's ability to perform daily activities and reach their goals.

Medicaid Eligible Child: Any child/youth in New York State who is eligible for Medicaid, whether eligible via income consideration, medically needy definitions, or categorical eligibility (e.g., foster care).

Medicaid Managed Care Plan: The mainstream Medicaid Managed Care Plan or HIV Special Needs Plan in which the child/youth is enrolled on the date of service, or which the child/youth has selected for enrollment and has provided written consent to share protected health information with prior to enrollment.

Medically Fragile: For the purposes of this Manual and Children's HCBS a "medically fragile child" is defined as an individual who is under 21 years of age whose target

population, risk factors, and functional criteria align with the Medically Fragile or Medically Fragile and DD LOC criteria.

Multisystem involved: Two or more child systems including child welfare, juvenile justice, Department of Homeless Services and/or other homeless services, OASAS clinics or residential treatment facilities or institutions, OMH clinics or residential facilities or institutions, OPWDD services or residential facilities or institutions, or having an established IEP through the school district.

Natural Supports: Individuals and informal resources that a family/caregiver can access, independent of formal services. These supports are a significant source of culturally relevant emotional support and caring friendships for children/youth and families. Natural supports can be short-term or long-term and are usually sustainable and available to the child/youth and family/caregiver after formal services have ended.

Out of Home Placement: Residential Rehabilitation Services for Youth (RRSY), Residential Treatment Facility (RTF), Residential Treatment Center (RTC), or other congregate care setting, such as SUD residential treatment facilities, group residencies, institutions in the OCFS system, or hospitalization.

Parent, guardian, or legally authorized representative: The individuals who have custody/guardianship of the child/youth and who are able to consent to the child/youth's services, when the child/youth is not of age to self-consent or does not have the mental capacity to self-consent to services. (Youth who are 18 years or older or under the age of 18 years old who are pregnant, married, or a parent can self-consent for the HH, C-YES, and HCBS).⁵

Note: When developing the POC, foster parents are encouraged to provide input. The final signature for the POC needs to be signed by the child/parent/guardian/legally authorized representative.

Person-Centered Care: Services should reflect a child/youth and family's goals and personal desired outcomes, and emphasize shared decision-making approaches that empower families, provide choice, and minimize stigma. Services should be designed to optimally treat illness, improve clinical and psychosocial outcomes, and emphasize wellness and attention to the family's overall well-being and the child/youth's full community inclusion. To be person-centered, services must be culturally appropriate, child/youth guided, and relevant.

Physical Disability: "Disability" under Social Security is based on one's inability to work. A person is considered disabled under Social Security rules if they cannot do work that s/he did before, SSA decides that s/he cannot adjust to other work because of his/her medical condition(s), and his/her disability has lasted or is expected to last for at least one year or to result in death.

⁵ This guidance does not change or modify the applicability of any law, regulation, or court order regarding custody, guardianship, right to consent to health care, or right to protected health information.

Recovery-Oriented: Services should be provided based on the principle that all individuals have the capacity to recover from mental illness and/or substance use disorders. Specifically, services should support the acquisition of living, vocational, and social skills and be offered in home and community-based settings that promote hope and encourage each person to establish an individual path towards recovery.

Restoration: Returning to a previous level of functioning.

School Setting: The place in which a child/youth attends school.

Scope: The service components and interventions being provided and utilized to address the identified needs of the child/youth.

Serious Emotional Disturbance (SED): A designated mental illness diagnosis according to the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for a child/youth who has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis. The functional limitations must be moderate in at least two of the following areas or severe in at least one of the following areas:

- Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries)
- Family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting)
- Social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time)
- Self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability)
- Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school)

Service Goal: A general statement of outcome relating to the identified need for the specific intervention provided.

Service Provider: Individuals/organizations that provide and are paid to provide services to the child/youth and family/caregiver.

Substance Use Disorder (SUD): A diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to the use of the substance. The diagnosis of a substance use disorder is based on criteria defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) and can be applied to all ten classes of

drugs (i.e. alcohol; cannabis; hallucinogens; inhalants; opioids; sedatives; hypnotics; anxiolytics; stimulants; tobacco; and other (or unknown) substances).

Trauma-Informed: Trauma-informed services are based on an understanding of the vulnerabilities or triggers experienced by trauma survivors that may be exacerbated through traditional service delivery approaches so that these services and programs can be modified to be more supportive and avoid re-traumatization. All programs should engage all individuals with the assumption that trauma has occurred within their lives (SAMHSA, 2014).

Youth: Individuals generally 14 years of age and older.

Appendix B: CMS Final Rule on HCBS Settings

According to [CMS requirements](#), any residential or non-residential setting where children/youth receive HCBS must have the following qualities:

1. The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
2. The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
3. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
4. Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
5. Facilitates individual choice regarding services and supports, and who provides them.

In a provider-owned or controlled residential setting, in addition to the qualities specified above, the following conditions must be met:

6. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
7. Each individual has privacy in their sleeping or living unit:
 - Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
 - Individuals sharing units have a choice of roommates in that setting. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
8. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
9. Individuals are able to have visitors of their choosing at any time.
10. The setting is physically accessible to the individual.

- Any modification of the additional conditions specified in items 1 through 4 above, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
- Identify a specific and individualized assessed need.
- Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
- Document less intrusive methods of meeting the need that have been tried but did not work.

Provider-owned and controlled standards 6-10 are the only standards that are modifiable, under certain conditions.

Include a clear description of the condition that is directly proportionate to the specific assessed need.

- Include regular collection and review of data to measure the ongoing effectiveness of the modification.
- Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- Include the informed consent of the individual.
- Include an assurance that interventions and supports will cause no harm to the individual.

Provider-owned and controlled standards 6-10 are the only standards that are modifiable, under certain conditions.

For standards 6-10, there cannot be restrictive rules that apply to all Children's Waiver recipients. Examples of restrictive rules include, set visitor hours in a residential setting, and only one time slot food/snacks are available. Standards 6-10 may be modified on a case-by case basis for a specific individual if it is done:

- When there is a *specific need* that has been identified that a participant requires staff support with (i.e., a diagnosis is not enough information to support modifying a standard)
- On a time-limited basis (reassessing periodically to see if the modification is still needed)
- After less restrictive and more positive approaches were tried and failed

Modification example: Jane requires assistance with managing her access to food/snacks due to her tendency to eat frequently, which raises her blood sugar levels. Staff tried counseling her but were not successful. With her (or her guardian/representative's) informed consent, staff will support her with accessing the snack cabinet for at least six months, documenting this in her plan.

The CMS Final Rule (§441.301(c)(4) and §441.710) defines the qualities that all home and community-based settings must possess in order to be in compliance with the rule. In the final rule, CMS also clarifies which settings do NOT qualify as home and community-based settings.

According to CMS, settings that DO NOT MEET the definition of being home and community based are:

- A nursing facility;
- An institution for mental diseases;
- An intermediate care facility for individuals with intellectual disabilities;
- A hospital; or
- Any other locations that have qualities of an institutional setting, as determined by the Secretary.

In addition, the final rule 441.301(c)(5)(v) specifies that the following settings are presumed to have the qualities of an institution (and therefore likely do not meet the HCBS standard without documentation to support otherwise):

- Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,
- Any setting that is located in a building on the grounds of, or immediately adjacent to, a public institution, or
- Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

Any modifications of these additional conditions must be supported by a specific assessed need and justified in the person-centered service plan.

The federal HCBS regulations also require that the Person-Centered Service Planning (PCSP) process must be met as outlined in the following requirements:

- Reflect
that the setting in which the individual resides is chosen by the individual.
 - The PCSP must ensure that the setting chosen by the individual is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community
- Be timely and occur at least annually at times and locations of the individual's convenience
- Assist the person in achieving outcomes they define for themselves, and in the most integrated community setting(s) they desire
- Ensure delivery of services in a manner that reflects personal preferences and choices
- Help promote the health and welfare of those receiving services
- Take into consideration the culture of the person served

- Include strategies for solving disagreement(s)
- Offer choices regarding the services and supports the person receives, and from whom
- Reflect the individual's strengths, preferences, needs (both clinical and support), and desired outcomes
- Provide necessary information and support to the individual to ensure that they can direct their planning process as much as possible
- Include people chosen by the individual
- Reflect services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports (unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports).
- Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, the plan must be written in plain language and in a manner that is accessible to individuals with disabilities and person who are limited English proficient.
- Identify the individual and/or entity responsible for monitoring the plan.
 - Indicate what entity or person will monitor the primary or main person-centered plan
- Be distributed to the child/youth and other people involved in the plan.
- Include those services, the purpose or control of which the individual elects to self-direct and prevent the provision of unnecessary or inappropriate services and supports.
 - Provide a method for the individual to request updates to their plan
- Document that any modification of the additional conditions, under 42 CFR 441.301(c)(4)(vi)(C) and (D), must be supported by a specific assessed need and justified in the PCSP. Any deviation from the standards at 42 CFR 441.301(c)(4)(vi)(C) and (D) will be justified and documented in the care plan with updated frequency, scope, and duration, and will be updated no less frequently than every 6 months.

APPENDIX C: PRIOR/CONCURRENT AUTHORIZATION GRID

HCBS	Prior Authorization	Concurrent Authorization	Additional Guidance
Caregiver/Family Advocacy and Support Services	No	Yes	Eligibility determination and plan of care (POC) are the only required elements for initial authorization. MMCPs will reimburse for initial authorization of 96 units or a total of 24 hours of service for a period of 60 days from the time that the MMCP receives notification from the HCBS provider.
Community Habilitation	No	Yes	Eligibility determination and POC are the only required elements for initial authorization. MMCPs will reimburse for initial authorization of 96 units or a total of 24 hours of service for a period of 60 days from the time that the MMCP receives notification from the HCBS provider.
Day Habilitation	No	Yes	Eligibility determination and POC are the only required elements for initial authorization. MMCPs will reimburse for initial authorization of 96 units or a total of 24 hours of service for a period of 60 days from the time that the MMCP receives notification from the HCBS provider.
Prevocational Services	No	Yes	Eligibility determination and POC are the only required elements for initial authorization. MMCPs will reimburse for initial authorization of 96 units or a total of 24 hours of service for a period of 60 days from the time that the MMCP receives notification from the HCBS provider.
Supported Employment	No	Yes	Eligibility determination and POC are the only required elements for initial authorization. MMCPs will reimburse for initial authorization of 96 units or a total of 24 hours of service for a period of 60 days from the time that the MMCP receives notification from the HCBS provider.
Environmental Modifications	Yes	Yes	\$25,000 annual calendar year limit; addressed in separate guidance
Vehicle Modifications	Yes	Yes	\$25,000 annual calendar year limit; addressed in separate guidance
Adaptive and Assistive Technology	Yes	Yes	\$15,000 annual calendar year limit; addressed in separate guidance

HCBS	Prior Authorization	Concurrent Authorization	Additional Guidance
Palliative Care (Counseling and Support Services, Pain and Symptom Management, Expressive Therapy, Massage Therapy)	Yes	Yes	<p>Palliative care benefits may not duplicate Hospice or other State Plan benefits accessible to participants.</p> <p>Expressive therapy limited to the lesser of four appointments per month or 48 units per calendar year.</p> <p>Massage therapy limited to no more than 12 appointments per calendar year.</p> <p>Counseling and Support limited to the lesser of five appointments per month or 60 hours per calendar year.</p> <p>Limits can be exceeded when medically necessary.</p>
Planned Respite	No	Yes	<p>Eligibility determination and POC are the only required elements for initial authorization. MMCPs will reimburse for initial authorization of 96 units or a total of 24 hours of service for a period of 60 days from the time that the MMCP receives notification from the HCBS provider. Billing for Respite must be based on in-person interactions with the Waiver child.</p> <p>Respite billing is limited to six (6) hours (24 units) per child per day.</p> <p>For Individual Respite the maximum of six (6) hours (24 units) is equivalent to a daily individual per diem rate.</p> <p>Group Respite billing is limited to six (6) hours (24 units) per child per day.</p> <p>Planned Respite will be authorized for utilization for no more than 7 consecutive days per calendar year. Anything beyond this utilization will require concurrent review.</p>
Crisis Respite	No	Yes	<p>No prior authorization is needed; MMCP may require a notification of care and require concurrent review if utilization exceeds 72 hour stay.</p>

APPENDIX D: TABLE OF RESPONSIBILITIES FOR HCBS WORKFLOW

Milestone Event	Responsible Entity			
	Enrolled in MMCP		FFS Medicaid	
	Enrolled in HH	Opt-out of HH, Served by C-YES	Enrolled in HH	Opt-out of HH, Served by C-YES
HCBS Provider referral	HHCM	C-YES	HHC M	C-YES
Notifies MMCP and HHCM of First Appointment	HCBS Provider	HCBS Provider	N/A	N/A
On-going POC updates	HHCM	MMCP	HHC M	C-YES
Request Authorization for Services	HCBS Provider	HCBS Provider	N/A	N/A
Major life event requiring POC update	HHCM	MMCP	HHC M	C-YES
Monitoring access to care	MMCP	MMCP	HHC M	C-YES
Annual reassessment	HHCM	C-YES	HHC M	C-YES

Appendix E: Training Grid

HCBS providers must have the following in place:

- Written policies and procedures that describe staff orientation
- Mandatory training and other offered trainings for staff
- Staff have the required training to provide care that is trauma informed, culturally competent, and appropriate to the developmental level of the population served
- Maintain documentation of staff completion of required trainings in accordance with the Children's HCBS Provider Manual and be able to provide training records to the State upon request to review. Additional information on State reviews will follow.

Mandatory training components can be delivered in one training or a series of trainings. The HCBS provider will need to maintain training records and training curriculum as evidence of meeting the requirements. Providers can seek community training available to them, partner with another agency, and/or develop a training within their organization to address the required training components. Mandated Reporter training must be completed prior to service delivery, and all other trainings must be completed within six months of hire date.

Training Required	Training Components Required
Mandated Reporter	Staff members are required to completed Mandated Reporter training prior to delivering HCBS.
Personal Safety/ Safety in the Community	<ul style="list-style-type: none"> • Safety awareness/office and community safety • Prevention/risk assessment for the field visits • Use of safety technology (e.g. use of mobile phones) • Transporting children/youth/families • Safety training/self-protection strategies • De-escalation techniques • Emergency protocols and resources (includes agency policies that address emergency procedures while delivering HCBS in the community and resources available to staff in the event of an emergency e.g. 911, on-call supervision) • Post incident reporting and response (includes agency policies that address incident reporting and procedures for staff providing HCBS in the community) • To ensure safety and protection of child/ youth, trainings will address professional boundaries, relationship boundaries, trauma, and a code of ethics for staff working with children/ youth.
Strength Based Approaches	<ul style="list-style-type: none"> • What are strength-based approaches? • Person-centered planning • Strength based information gathering • Collaboration with child/youth/family and community (e.g. family-guided, youth-driven, etc.) • Identifying strengths, protective factors and assets • Cultural and linguistic competence
Suicide Prevention	<ul style="list-style-type: none"> • Myths and misconceptions of suicide • Risk factors • High risk populations

Training Required	Training Components Required
	<ul style="list-style-type: none"> • Warning signs • How to help (assess for risk of suicide and harm, encourage appropriate professional help) • Action/safety planning identify resources in the community (i.e., emergency services and mental health professionals))
Domestic Violence Signs and Basic Interventions	<ul style="list-style-type: none"> • What is domestic violence? • Prevalence • Types of abuse • Cycle of violence/pattern of abuse • Domestic violence effects on children • How to help • Action/safety planning
Trauma Informed Care	<ul style="list-style-type: none"> • What is trauma? • Prevalence/findings (e.g. ACES) • Impact of trauma • Trauma informed care approach (i.e., strength-based, person and family centered, culturally aware, meeting language needs, performing collaborative and coordinated care, etc.).

Appendix F: Service Animal Guidance

The NYS Children's Waiver recognizes the importance of service animals in the lives of individuals with various disabilities such as those that substantially limit one or more major life activities. Service animals are more than pets, and more than companions; they are a working animal and the important work they do enhances independence for children/youth with physical, cognitive, and developmental disabilities. Service animals perform some of the functions and tasks that the individual with a disability cannot perform for him or herself.

Service animal is defined by the Americans with Disabilities Act (ADA) [Title II \(State and local government services\)](#) and [Title III \(public accommodations and commercial facilities\)](#) as, "any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability." The work or tasks performed by a service animal must be directly related to the individual's disability. These tasks may include, but are not limited to:

- assisting individuals who are blind or have low vision with navigation and other tasks,
- alerting individuals who are deaf or hard of hearing to the presence of people or sounds,
- providing non-violent protection or rescue work,
- calming a person with Post Traumatic Stress Disorder during an anxiety attack,
- pulling a wheelchair,
- protecting a person who is experiencing a seizure,
- alerting individuals to the presence of allergens,
- retrieving items such as a telephone or medicine or reminding someone to take prescription medications,
- providing physical support and assistance with balance and stability to individuals with mobility disabilities, and,
- helping persons with psychiatric and neurological disabilities by preventing or interrupting impulsive or destructive behaviors.

Additional guidance on the ADA's service animal provisions can be found in the following publications:

- [Title III Regulation Supplement - Current as of January 17, 2017 Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities](#)
- [Frequently Asked Questions about Service Animals and the ADA](#)
- [Public Access Test Checklist for Service Animals](#)

Dogs whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA.

This definition does not affect or limit the broader definition of "assistance animal" under the Fair Housing Act or the broader definition of "service animal" under the Air Carrier Access Act.

- [U.S. Department of Housing and Urban Development: Service Animals and Assistance Animals for People with Disabilities in Housing and HUD-Funded Programs](#), FHEO-2013-01 (April 25, 2013)
- 49 U.S.C. § 41705; see ["Nondiscrimination on the Basis of Disability in Air Travel,"](#) 14 C.F.R. Part 382 (United States Department of Transportation 2014) Nondiscrimination on the basis of disability in air travel

The ADA requires that service animals be under the control of the handler at all times and be harnessed, leashed, or tethered, unless these devices interfere with the service animal's work or the individual's disability prevents him from using these devices. Individuals who cannot use such devices must maintain control of the animal through voice, signal, or other effective controls.

Policy

This policy provides guidance on the use and funding of service animals by New York Children's Waiver participants. Service animals funded by the New York Children's Waiver must meet the following criteria.

- The request for funding must follow the [Guidelines for Authorizing Assistive Technology](#) including:
 - Documenting the need for assistance in the individual's POC
 - A physician's order stating the need for assistance
 - Clinical justification from the appropriate clinician and/or service specialist to assess the individual's need for the request service animal and to indicate how the service animal meets the needs of the individual in the most cost effective manner; the clinical justification must include a home environment assessment to determine if there are any obstacles to the use of the service animal in the home
 - Submitting the Description and Cost Project Form to the Managed Care Organization (MCO) or LDSS as appropriate
- A licensed veterinarian shall be engaged to certify the following:
 - The service animal is trained to perform the activities needed by the individual as identified in the POC and clinical justification. See Appendix 1 for ADA requirements regarding training.
 - The service animal must pass obedience level 3 and/or the national public access test, be registered and licensed as required by local ordinance,

and current on all vaccinations. See Appendix 2 for a National Public Access checklist for basic obedience requirements.

- Assistance teams are tested initially and verified every 24 months to ensure they continue to work well together and accomplish the identified tasks. Additional training may be conducted if medical necessity is determined based on the changing needs of the individual.

Services include:

- A. Evaluation of the assistive technology/service animal needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant
- B. Services consisting of purchasing assistive technology devices/service animal for the participant
- C. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices for the participant
- D. Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant
- E. Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participant

Service animals are expected to be a one-time only purchase. Replacements will be paid if documented as a necessity and approved by the State or its designee. Maintenance will only be approved when it is the most cost effective and efficient means to meet the need, and other options are not available through the 1905(a) Medicaid State Plan or third-party resources.

- Refresher training for the service animal every 24 months is an allowable expense. Additional training for the service animal would be paid for if warranted by a change in the participant's condition and the appropriate documentation is provided.
- Services available through the Children's Wavier cannot duplicate services otherwise available through the 1915(a) Medicaid State Plan or other federal/state funding streams. Equipment must be beyond the scope of Durable Medical Equipment (DME). Vocational Rehabilitation funding must be sought prior to Medicaid funding.
- All service animal costs require prior approval from the LDSS in

conjunction with DOH or the MCO. As a type of Adaptive and Assistive Technology, service animal requests are subject to a \$15,000 per calendar year soft limit. The State may consider exceptions when medically necessary, including but not limited to a significant change in the participant's needs or capabilities.

Appendix G: Medicaid Eligibility Guidance

Medicaid Eligibility Status Impact on HCBS Eligible Children

This guidance is to provide clarification regarding Medicaid eligibility related to the Children's Waiver and changes due to the approved 1115 Waiver. This guidance explains how the receipt of services are related to waiver and Medicaid eligibility for "*Family of One*" children. Specifically, the guidance explains when either Care Management or HCBS are required for children to obtain eligibility for the Children's Waiver and Medicaid eligibility.

Together, the 1915(c) Children's Waiver and the 1115 MRT waiver authorities provide Medicaid eligibility for children meeting the HCBS eligibility criteria under the Children's Waiver. The 1915(c) Children's Waiver was implemented on April 1, 2019 and consolidated six children's HCBS waivers into one comprehensive waiver. The children's 1115 MRT waiver amendment was approved on August 2, 2019 to allow "*Family of One*" to children meeting the 1915(c) Children's Waiver criteria, who only receive HH Care Management services, to retain their Waiver eligibility status. This allows the child to have Medicaid eligibility determined under a "*Family of One*" budget if not otherwise eligible under community budgeting. The two authorities allow all children and youth eligible for the Waiver to have:

- Greater ease of enrollment into Children's Waiver
- Access to all HCBS (Home and Community Based Services) as needed
- Greater flexibility for HCBS to be delivered in natural environments for better outcomes
- Retain eligibility for Medicaid if "*Family of One*" and eligible for the Children's Waiver

HCBS Care Management

All children/youth enrolled in the Children's Waiver need care coordination services. HH comprehensive care management provides the care coordination service required under the Children's Waiver. If a child/youth is eligible for the Children's Waiver, they automatically receive HH care management and a separate HH eligibility determination is not needed. As HH is an optional benefit, a child/family can opt-out of HH services. For a child/youth who opts-out of HH services, their care coordination will be provided by the Independent Entity of C-YES and, if enrolled in MMCP, by the MMCP care manager. A child/youth who needs HCBS, but is not enrolled in Medicaid, will be referred to C-YES who will determine HCBS/LOC Eligibility and assist with establishing Medicaid eligibility. Once the child/youth is HCBS and Medicaid eligible, the child/family can choose who they would like to provide care coordination, HH or C-YES.

"Family of One" Medicaid Eligibility

"Family of One" is a phrase used to describe a child that becomes eligible for Medicaid through the use of institutional eligibility rules. If a child is not otherwise eligible for Medicaid when counting parental income (and/or resources, if applicable), these rules allow for the child to have Medicaid eligibility determined as a "*Family of One*", using only the child's own income (and resources, if applicable). If a child/youth is not

currently receiving Medicaid due to parental income (and/or resources, if applicable) and the child/youth is in need of waiver services, when the child/youth is found HCBS/LOC eligible and able to obtain a capacity slot, then based upon waiver eligibility, the child will have Medicaid eligibility determined as a “*Family of One*”.

Note: There is a hierarchy that must be used in determining a child/youth's Medicaid eligibility. This hierarchy requires that parental income information be included in the child's Medicaid application, even if the income is not ultimately used under a “*Family of One*” budget. If the child is in a medically fragile diagnostic group or certified disabled, parental resource information and any income of non-waiver siblings under age 18 will also need to be included on the Medicaid application. In addition, as part of the Medicaid eligibility determination, children/youth in a medically fragile diagnostic group will have a disability determination made by the State Disability Review Team, if disability status has not already been established by the Social Security Administration. Pending the disability determination, Medicaid coverage will be authorized for such children under an ADC-related “*Family of One*” budget, but the child/family will be required to comply with the disability determination.

Once a child/youth obtains Medicaid under “Family of One” they must be continually enrolled and receiving HCBS or HH care management services (as noted below) to continue their “Family of One” eligibility for the Medicaid. Any “*Family of One*” child/youth can also receive other Medicaid services (i.e. State Plan services) such as Private Duty Nursing, CFTSS, pharmacy, hospital, physician, etc. Once a child/youth with “*Family of One*” Medicaid is no longer eligible for the Children's Waiver and/or doesn't receive HCBS or HH care management, they may lose their Medicaid eligibility altogether or they may have to meet a large spenddown each month in order to access Medicaid services.

“Community Eligible Medicaid” is when a child/youth is determined eligible for Medicaid based on a budget that includes family income (and resources when applicable) in the budget calculation (MAGI, ADC-related or SSI-related community budget) and is not tied to Children's Waiver eligibility.

“Family of One” and Care Management

Children/youth who meet HCBS/LOC eligibility (target, risk and functional) and obtain a capacity slot, must be connected and in receipt of at least one HCBS on a monthly basis. Under the new Children's Waiver/1115 Waiver authorities, any “*Family of One*” (with a KK code) child/youth meeting the eligibility criteria for the 1915(c) Children's Waiver must receive HH care management services or HCBS.

For all children/youth whether Community Eligible or “*Family of One*” Medicaid, a determination of services necessary must be supported by an assessment of needs and strengths with the child/family and their identified care team as developed in the person-centered POC. The Children's Waiver offers an expanded array of service options for children and families. Based on the needs and priorities of the family, the HHCM can link the family with the appropriate services to best support their needs, including

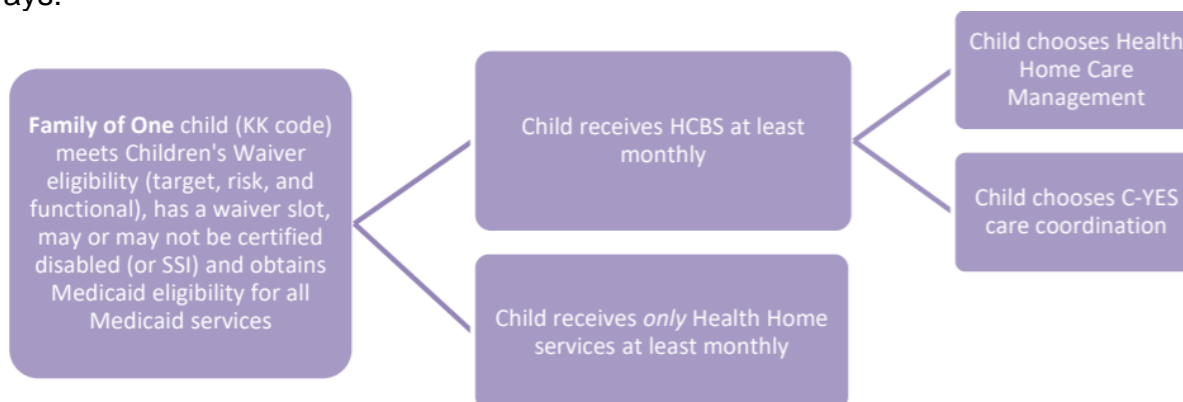
Private Duty Nursing under the Medicaid State Plan. HCBS found necessary to maintain the child/youth in their home should be supportive and appropriate for the child/youth's needs. The child/youth's care record must reflect the needs and necessary services through appropriate documentation.

If an HCBS/LOC eligible child/youth has no need for an HCB Service, **and** is only eligible for Medicaid under a "Family of One" budget, then similar to the previous HCBS Waivers, if the child/youth receives HH Care Management in order to be maintained in the home, the child/youth qualifies for the Children's Waiver. HH care management may be the sole service for a "Family of One" child/youth to continue waiver eligibility and have access to other needed Medicaid services. In these cases, **only** HH comprehensive care management with monthly in-person monitoring, regardless of acuity level, is allowable. C-YES/MMCP care coordination will not meet this requirement; this restriction must be explained to the child/family. In contrast, a community Medicaid eligible child must receive an HCBS waiver service monthly to continue waiver eligibility.

See [Children's Waiver - HCBS Waiver Eligibility Service Requirements](#) and [Children's Waiver - Medicaid Eligibility Status Impact on HCBS Eligible Children](#) for more details regarding this policy.

HH care management for an HCBS/LOC and "Family of One" eligible child/youth, in absence of any other HCBS waiver service, requires that the POC outline frequency, scope and duration for the HH care management services.

Figure 1: "Family of One" children may obtain waiver and Medicaid eligibility in two ways:

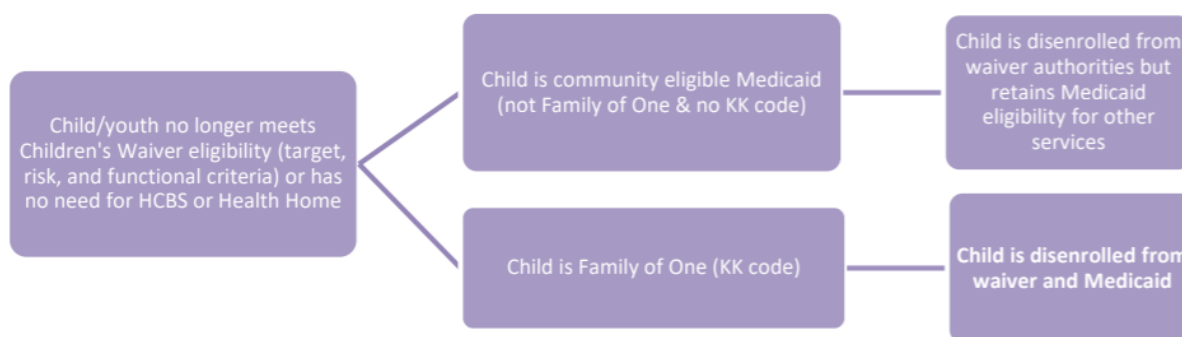


As noted in the figure above, children and youth meeting the Children's Waiver eligibility criteria, assigned to a capacity slot, and receiving HCBS, may receive care management either through HH or C-YES/MMCP based upon child/family choice. The difference between HH comprehensive care management and C-YES HCBS care coordination, with MMCP care management as applicable, must be explained to the child/family so an informed choice can be made.

Disenrollment from Waiver

A child/youth who does not meet the Children's Waiver eligibility criteria and who has no need for HCBS or HH care management, should be disenrolled from the Children's Waiver. In addition, once a child/youth has been successful in reaching the goal of the HCBS (i.e. Environmental Modification) and no other HCBS is needed, possible discharge from the waiver authorities should be reviewed and determined if other HCBS goals are not appropriate.

Figure 2: Disenrollment from Waiver if child/youth does not meet Children's Waiver criteria or need HCBS/HH services.



"Family of One" children/youth (with a KK code) who do not require at least one HCBS monthly but continues to meet the eligibility criteria for the Children's Waiver must receive HH Care Management and have HCBS in their plan of care for health and welfare monitoring to maintain their Medicaid eligibility.

If a child/youth has community Medicaid (without a KK code) and does not need HCBS monthly but needs State Plan services or other supports to be safe and supported at home and in their community, will be disenrolled from the Children's Waiver. The child/youth will retain Medicaid eligibility to receive all other medically necessary Medicaid services.

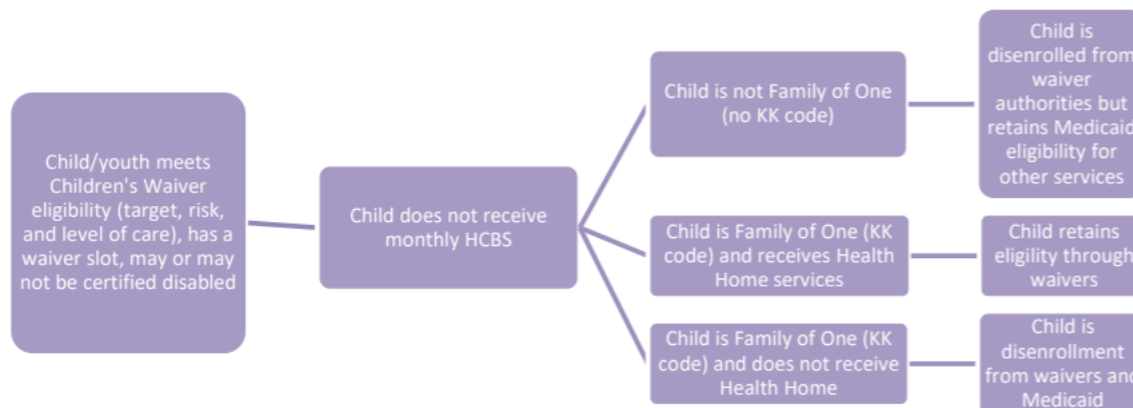
Receipt of HCBS or HH Care Management Services

If State Plan Services such as CFTSS or Community First Choice Options (CFCO) can meet a child/youth's needs, then these services must be accessed prior to HCBS Services. This does not prohibit a child/youth from receiving both State Plan services and HCBS at the same time, as long as it is reflective of the child/youth's needs in the person-centered POC and does not result in duplicative services. The child/youth's needs should be continually monitored and reviewed with the family and treating service providers. If it is determined that the child/youth's needs are met via non-HCBS programs and/or services, HCBS discharge should be explored.

If State Plan or CFCO services alone meet the needs of the child/youth, then the child/youth **should not be** enrolled in the Children's Waiver unless the child/youth is only eligible for Medicaid under *"Family of One"* (KK code). A *"Family of One"* child/youth who meets the Children's Waiver eligibility criteria and receives HCBS

and/or HH Care Management, can access other State Plan services such as Private Duty Nursing, and will continue to meet waiver and Medicaid eligibility requirements.

Figure 3: Disenrollment from waiver if child/youth doesn't receive monthly HCBS but continues to meet Children's Waiver criteria.



Process for Renewing and Establishing Medicaid for Children's Waiver

Participants

Background – Enrollment in the Children's Waiver

In preparation for the implementation of the Children's Waiver on April 1, 2019, a streamlined process was developed to determine Medicaid eligibility, Children's Waiver Home and Community Based Services (HCBS) eligibility, and subsequent entering of Children's Waiver Recipient Restriction Exception (RRE) codes (K-codes) for wavier enrolled children/youth.

Child/Youth with Active Medicaid

When a child/youth has active Medicaid, their HCBS eligibility determination is performed by the HH CMA's accessor/care manager, unless the child/youth has opted-out of HH, in which case the HCBS eligibility determination would be conducted by C-YES. DOH Capacity Management Team (CMT) receives a report of all completed HCBS/LOC eligibility determinations. The CMT will review the report for new eligible children/youth, notify the HHCM/C-YES accessor of slot availability, and enter the appropriate K-codes into eMedNY to indicate HCBS/LOC eligibility and target population.

The K-code of K1 in eMedNY, indicates to MMCP, the LDSS, HCBS providers, and others, that the child/youth is eligible and enrolled in the HCBS Children's Waiver.

Children/youth who are enrolled in HH and want/need HCBS, the HHCM can complete and determine HCBS/LOC eligibility. If the child's/youth's Medicaid recertification is upcoming, if there is a concern that the child's/youth's Medicaid may lapse, or there is a need for "Family of One" (KK code) Medicaid budgeting, the HHCM can determine HCBS/LOC eligibility and work with the LDSS/HRA. *The HHCM should not refer an enrolled HH child/youth to C-YES for HCBS/LOC eligibility.* It is imperative that children/youth are not passed back and forth between HH and C-YES.

Child/Youth without Active Medicaid

When a child/youth who is not enrolled in a HH and does not have active Medicaid seeks HCBS eligibility, their HCBS eligibility determination must be performed by C-YES. The CMT receives a report of all completed HCBS/LOC eligibility determinations. The CMT will review the report for new eligible children/youth and will notify the C-YES accessor of slot availability. The LDSS is responsible for entering the appropriate K-codes after the child/youth is determined Medicaid eligible as outlined by [Administrative Directive Memorandum](#).

Monitoring Active Medicaid Status – Children Enrolled in Children's Waiver

According to the **HH Standards and Requirements of HH, Care Management Agencies, and Managed Care Organizations**, the HHCM must verify an individual's Medicaid eligibility/status on a regular basis and prior to billing for services. The HHCM should be aware of the member's Medicaid recertification date and should assist the member/family with Medicaid recertification whenever possible.

More information on the requirements can be found in the [Consolidated Children's Waiver and Medicaid Case Processing Requirements](#) document.

For children/youth enrolled in the HCBS Children's Waiver, it is imperative that HCBS providers verify the child/youth's Medicaid eligibility **plus** HCBS enrollment (through eMedNY), prior to providing services and billing. HCBS providers may not bill while the child/youth does not have active Medicaid. If the HCBS provider continues to deliver services while the child/youth's Medicaid enrollment is not active, the provider is at risk of not recovering those costs.

Loss of Active Medicaid – Children Enrolled in Children's Waiver

If an HCBS enrolled child/youth loses their Medicaid, the HHCM or C-YES should reach out to the LDSS to understand the reason for the loss of Medicaid and to share with the LDSS that the child/youth is enrolled in the HCBS Children's Waiver and has active K-codes. If the family's financial situation has changed so that they are no longer eligible for community Medicaid, the LDSS should conduct the "Family of One" (KK code) Medicaid budgeting to determine Medicaid eligibility for the child/youth, which, if found eligible, would allow the child/youth to remain in HCBS.

HCBS enrolled children/youth receiving HH care management who lose their Medicaid should *not* be referred to C-YES for assistance with Medicaid. It is the responsibility of the HHCM to assist in restoring active Medicaid status, if possible.

When a member's Medicaid is no longer active, the HHCM can continue to work with the member and the LDSS for up to 90 days to assist with the re-establishment of Medicaid. The HHCM may continue to work with the member but may not bill for services while the member's Medicaid is inactive. The HH may retroactively bill for care management services provided during this 90-day period prior to the date Medicaid is re-established, if the member is later deemed eligible, enrolled in Medicaid, and the Medicaid date is effective for this time period. If the HHCM learns that the

member/family's Medicaid cannot be restored, the HHCM must initiate the HH disenrollment planning process.

For children/youth receiving HCBS care coordination through C-YES, C-YES may work with the member/family and/or LDSS to assist with re-establishing Medicaid eligibility.

For further information, refer to the [Children's Waiver Medicaid Eligibility Status Impact on HCBS Eligible Children](#) guidance document.

For any questions, please reach out to your lead HH for assistance. DOH Children's Transformation contact information: BH.transition@health.ny.gov or HHSC@health.ny.gov

Medicaid Excess/Surplus Income (Spenddown) Program Guidance for Children's Care Management and HCBS

The following information outlines the Medicaid "Spenddown" program and its impact on Children's HH care management and/or Children's Waiver enrollment of HCBS.

What is the Spenddown Program?

The Spenddown program is a way for individuals with income over the Medicaid level (excess/surplus income) to receive Medicaid coverage. The individual must submit paid or incurred medically necessary bills equal to or greater than the monthly excess income amount. The individual may also pay the amount of their monthly excess to the local district (for upstate residents, the County LDSS, or, for NYC residents, the HRA). This is called Pay-In.

How Does an Individual Satisfy or Meet Their Monthly Spenddown Amount?

When an individual has a monthly spenddown, it means the individual's income is above the Medicaid income limit and must "spenddown" to the Medicaid limit by submitting paid or unpaid medically necessary expenses, such as out-of-pocket medical costs (co-pays for doctor appointments and/or pharmacy). The individual can also choose to pay their monthly spenddown by cash/check/money order directly to their LDSS/HRA.

- Medically necessary costs and Waiver Services can be utilized for the monthly spenddown. The family and providers should work with the LDSS/HRA to understand which service costs can be utilized for spenddown.
- HH care management services cost cannot be utilized for spenddown.
- The individual can pay their spenddown monthly or pay months in advance.

Please note: When a child/youth has Family of One Medicaid budgeting, parental medical expenses cannot be applied toward a child's/youth's spenddown.

When an individual is determined Medicaid eligible with a monthly spenddown, the individual does not have Medicaid coverage until the monthly spenddown is met.

- Once the individual meets their monthly spenddown, s/he is eligible for Fee-for-Service (FFS) or regular Medicaid coverage only.
- Individuals participating in the spenddown program are not eligible to join a MMCP.

What Occurs if an Individual Does Not Satisfy Their Monthly Spenddown Amount?

If the individual does not meet their monthly spenddown, then services rendered such as HH care management and other Medicaid services cannot be billed. HHCMs, HCBS providers, and other Medicaid service providers should work with the family to assist in meeting their spenddown so services can be delivered. Providers should verify monthly that the family's monthly spenddown is met to provide services and be able to bill for those services.

- If an individual does not meet their spenddown for 90 days or longer, the LDSS/HRA may close the individual's Medicaid case, resulting in loss of Medicaid, Waiver Services, and HH care management services; therefore, care managers and providers should assist individuals not meeting their spenddown to avoid disenrollment.
- If an individual loses coverage, the LDSS/HRA, the care manager, and providers should work to connect the individual to other non-Medicaid services.

Children's Waiver Participant and Spenddown:

When a child/youth is eligible for the Children's Waiver and their Medicaid eligibility is being determined, if they are found Community Medicaid eligible with a spenddown, then the LDSS/HRA will complete Family of One budgeting. In many cases, the child/youth found to be eligible for Medicaid through Family of One budgeting won't have a spenddown, therefore the required monthly Waiver Services can be delivered without concern for meeting a spenddown. In some cases, Family of One Waiver-eligible children/youth will have a spenddown that would have to be met prior to Waiver Services being provided.

How to Identify an individual Participating in the Spenddown Program:

To systematically identify an individual who has spenddown coverage in ePACES, upon entering the individual's Client Identification Number (CIN), the following messages will come up:

❖ **"No Coverage-Excess Income"** until the monthly spenddown is met

Once the individual meets their monthly spenddown, ePACES will reflect the following message:

❖ **"Outpatient Coverage"** or

❖ **"Outpatient Coverage with Community-Based Long-Term Care"**

Outpatient care is sometimes referred to as ambulatory care. It is medical care or treatment that does not require an inpatient stay in a hospital or medical facility. Some examples of outpatient services are:

- Treatment and Preventative Health and Dental Care (Doctor, Dentist)
- Eye Exams, Eyeglasses
- Prescription Drugs
- Laboratory and X-Rays
- Medical Supplies
- Care in a Hospital that does not Result in the Individual Being Formally Admitted to the Hospital for an Inpatient Stay (Emergency Room/Observation)
- Transportation to and from Necessary Medical Services

If the individual meets their monthly spenddown for a six-month period, ePACES will reflect the following message:

❖ **“Full Coverage” or “Community Coverage with Community Based Long-Term Care (CC with CBLTC)”**

Any questions or for further explanation concerning how to meet a monthly spenddown should be directed to the Medicaid case worker at the individual's LDSS/HRA. Upstate and NYC individuals can also contact the Medicaid Help Line at 1-800-541-2831 for assistance.

Appendix H: HCBS LOC Eligibility Guidance

Care Management Requirements for HCBS Eligible Children

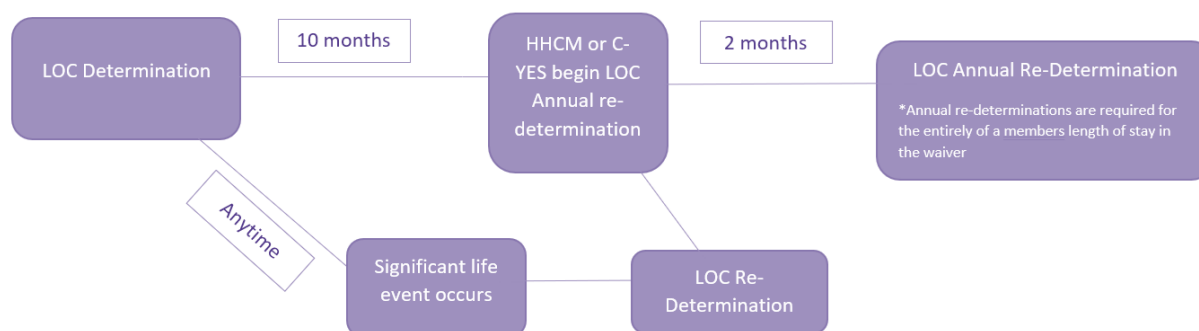
This guidance is to provide clarification regarding Home and Community Based Services (HCBS) requirements for care managers to ensure HCBS eligible children/youth obtain the services as required for the child/youth to maintain Waiver eligible. The 1915(c) Children's Waiver was implemented on April 1, 2019 and consolidated the six children's HCBS waivers into one comprehensive waiver. Each waiver had nuance differences and different HCB Services. Additionally, with the consolidated Children's Waiver now directly connected to HHSC's program, there are an increased number of care managers coordinating care for HCBS eligible children, when previously they had not done so. As such, the following is to clarify the requirements for services of HCBS eligible children within the Children's Waiver.

HCBS Level of Care (LOC) Determination:

The new consolidated 1915(c) Children's Waiver for HCBS requires an annual (365 days) HCBS Level of Care (LOC) Eligibility Re-determination to be completed for the child/youth to remain in the Waiver and continue receiving Waiver services.

The HHCM or C-YES staff are required to complete this eligibility determination prior to its annual expiration. The annual re-determination should begin 2 months prior to the expiration of the current HCBS/LOC determination. It is the HHCM's or C-YES staff's responsibility to know and understand the requirements and necessary paperwork needed to make an HCBS/LOC eligibility determination. For the target populations of Developmental Disability in Foster Care and Developmental Disability Medically Fragile, it is imperative that the HHCM or C-YES staff work with the OPWDD DDROs to establish timely HCBS redeterminations.

If a child/youth experiences a significant life event, as defined as a significant impact/change to the child's or caregiver's functioning and their daily living situation, a new HCBS eligibility determination will be needed. With all new HCBS/LOC Eligibility Determinations, the annual determination timeline resets with the completion of a new assessment outcome.



If a child/youth enrolled in the Children's Waiver is hospitalized or placed in an HCBS restricted setting, then the child/youth can remain enrolled in the Children's Waiver in such setting for up to 90 days.

During the 90 days stay:

- For children/youth in a HH, the MAPP segment would be "pended", and no billing would occur while the child was in the restricted setting. (Please refer to the [HH Continuity of Care Policy](#))
- The HH, C-YES or MMCP care manager, as applicable, should notify all care team members of the child's/youth's placement.
- The HH, C-YES or MMCP care manager, as applicable, will stay in contact with the hospital or HCBS restricted setting and request to be notified 30 days or as soon as possible, for shorter lengths of stay, prior to discharge.

Length of Stay – 90 days or shorter:

- The HH, C-YES or MMCP care manager, as applicable, will request to be notified when the child/youth will be discharged.
- Whenever possible, the HH or C-YES staff will conduct a new HCBS/LOC Eligibility Determination prior to discharge to ensure continuous waiver eligibility, will update the plan of care, as needed, and link the child/youth to service upon discharge.

Length of Stay – longer than 90 days:

- Once the child/youth's length of stay is beyond 90 days, the HH or C-YES staff will disenroll the child/youth from the Children's Waiver providing proper notification to the child/family of the notice of decision, as well as notifying DOH Capacity Management. (*Those with "Family of One" Medicaid based upon waiver eligibility may lose their Medicaid*)
- The HH or C-YES staff will ask the hospital or HCBS restricted setting to notify when the child/youth is being discharged, if the child/youth will need and want HCBS upon discharge. An HCBS/LOC Eligibility Determination can be conducted to determine if the child/youth can be re-enrolled in the Children's Waiver.

Monthly HCBS Required

Children/youth who meet HCBS/LOC eligibility (target, risk (when needed), and functional) and obtain a [capacity slot](#), must be connected and in receipt of HCBS on a monthly basis. The determination of services necessary must be supported by an assessment of needs and strengths with the child/family and their identified care team to develop a person-centered POC. The Children's Waiver offers an expanded array of service options for children and families. Based on the needs and priorities of the family, the care manager will link the family with the appropriate services to best support their needs (including other Medicaid needed services). HCBS found necessary to maintain the child/youth in their home should be supportive and appropriate for the child/youth's needs. The child/youth's care record must reflect the needs and necessary services through appropriate documentation.

If a child/youth has been determined eligible for HCBS and the child/family consents to receive HCBS, then at least **one** HCBS must be received monthly to maintain eligibility for the Children's Waiver. If the child/youth is not connected to an HCBS upon eligibility being determined or misses monthly HCBS, then the HH, C-YES or MMCP care manager, as applicable, must document efforts made to ensure access in the case record. If there is a concern regarding the child/family's interest in continuing HCBS and issues occur regularly, then the HH, C-YES, or MMCP care manager, as applicable, should review quarterly (three months) HCBS with the child/family and care team to determine if HCBS should be continued, terminated, or changed and/or if a referral to a different provider/service is needed.

Monthly HCBS Requirement and Accessibility

Children/youth enrolled in the waiver who need at least one HCBS monthly to safely live in their home and community must receive the HCBS needed for health, safety, and welfare. Due to their high needs, children/youth with a Children's Waiver plan of care requiring HCBS cannot be placed on HCBS provider's waitlist for all their identified and referred HCBS.

If a child/youth has been assessed as needing HCBS to be maintained in the community, HHCM, C-YES or MMCP must ensure the child/youth has access to the HCBS outlined on the plan of care. If the child/youth does not have access to monthly HCBS, then the HHCM, C-YES or MMCP, as applicable, must document efforts made to ensure access in the case record.

HHCMs, C-YES, or MMCP, as applicable, must make every effort to find available HCBS and HCBS providers that meet the identified needs of the child/youth. The child/youth **must** be referred to another HCBS provider in their service area with the capacity to serve the child/youth instead of being waitlisted. If the child/family does not want another provider, the child/youth must receive **at least one** service monthly or be in jeopardy of losing their HCBS.

If the HHCM or C-YES staff cannot find available HCBS, then they should contact the child/youth's MMCP, if applicable. The HH CMA must contact the lead HH for assistance to ensure the health and welfare of the child. The lead HH should alert DOH or the MMCP of the access issue and work with the care manager to provide necessary services to enrolled children.

If access issues occur regularly, then the HH, C-YES, or MMCP, as applicable, should review quarterly (three months) HCBS with the child/family and care team to determine if HCBS should be continued, terminated, or changed. HHCMs and care management agencies should contact their lead HH with questions or contact the DOH HHSC@health.ny.gov.

Matching Services to Need

Due to the transformations staggered implementation timeline, children/youth may be receiving and or referred to multiple services of both the Children's Waiver and the new

State Plan Services of CFTSS. It is important to ensure that through a person-centered POC development and service review, that children/youth's needs are matched with specific services that they can obtain and regularly receive. This does not prohibit a child/youth from receiving both State Plan services and HCBS at the same time, as long as it is reflective of the child/youth's needs in the person-centered POC and does not result in duplicative services.

Specifically, community Medicaid eligible children/youth who have all of their needs met through only State Plan Services of CFTSS or Community First Choice Options (CFCO) services, should be disenrolled from the Children's Waiver. In addition, once a child/youth has been successful in reaching the goal of the HCBS (i.e. Environmental Modification) and no other HCBS are needed for the child to be maintained in the community, possible disenrollment from the Children's Waiver should be reviewed and determined if other HCBS goals are not appropriate.

Requirements Regarding the Children's Waiver HCBS Participants Placed in a Restricted Setting

When a child/youth enrolled in the Children's Waiver is hospitalized or placed in an HCBS restricted setting, the child/youth may remain in such setting for up to 90 consecutive calendar days while maintaining enrollment in the Children's Waiver. If the waiver child/youth is also enrolled in the HH program when entering an HCBS restricted setting, the HHCM must "pend" the enrollment segment in the MAPP tracking system. The HH and HCBS providers are not able to bill while the child/youth is in a restricted setting, unless otherwise noted below.

When the child/youth remains in a hospital or restricted setting for more than 90 consecutive calendar days, the child/youth must be disenrolled from the Children's Waiver. The family/child will be issued a NOD explaining the reason for the disenrollment from the Children's Waiver. The HHCM or C-YES will notify the DOH CMT through the HCS regarding the Children's Waiver disenrollment following information outlined in the [Communication with DOH Capacity Management for the Children's Waiver](#) guidance document. The CMT, upon receipt of the notification, will end date the K-codes on the child's/youth's case based upon the date given by the HHCM or C-YES.

In keeping with the [Continuity of Care and Re-Engagement for Enrolled Health Home Members](#) policy, in the 30 days prior to the member's discharge from the restricted setting, the care manager must participate in active discharge planning activities to re-engage the member, the member's enrollment segment must be changed to 'active' status in the MAPP tracking system, and the care management agency may bill for services provided during the 30-day period. The HHCM must also conduct the HCBS/LOC Eligibility Assessment 30 days prior to discharge from the restricted setting, if possible, or within 30-days after discharge to determine HCBS re-eligibility (if previously disenrolled from HCBS) and to ensure an updated POC and necessary services are in place to assist the child/youth in transitioning back to their home and/or community.

For any questions, please reach out to your lead HH for assistance, DOH Children's Transformation contact at BH.transition@health.ny.gov or HHSC@health.ny.gov.

HCBS Determination for Children Discharging from OMH Residential Treatment Facility or Psychiatric Center

This guidance describes procedures for making 1915(c) Children's Waiver Home and Community Based Services (HCBS) referrals for children prior to or after being discharged from OMH Licensed Residential Treatment Facilities (RTFs) or OMH State Operated Psychiatric Centers Serving Children (State PCs).

When a child/youth enters an RTF or State PC, the DOH, in conjunction with OMH, is responsible for (re)determining Medicaid eligibility for the child/youth. When Medicaid eligibility is established, the child/youth is enrolled in Medicaid under District 97. This eligibility continues while the child/youth is in the RTF or State PC and continues **for the month of discharge and one month after the month of discharge**. This extension is to prevent a gap in coverage and allow time for the LDSS, NYC HRA to determine continued Medicaid eligibility.

For children/youth who have Medicaid coverage under OMH District 97, upon return to their county of residence post discharge, the LDSS will extend Medicaid coverage beyond the month after discharge, if necessary, to complete a redetermination of Medicaid eligibility. If the child/youth is not otherwise eligible for Medicaid based on household income and/or assets, but is eligible for HCBS, Family of One budgeting will be used to determine Medicaid eligibility. A new Medicaid application is not required upon RTF/PC discharge in these situations; however, the local district may require additional information in order to determine the continued eligibility of the child/youth.

Note: Children with SSI Medicaid have uninterrupted Medicaid through a separate automated process. OMH extends SSI Medicaid for 10 days beyond the OMH Medicaid district 97 case closing transaction date, and the SSI Medicaid coverage is transitioned automatically to the discharge District of Fiscal Responsibility (DFR).

When a child/youth enters an RTF or State PC, the OMH Patient Resource Office (PRO) will complete a Medicaid eligibility determination. There are 3 scenarios to consider when referring for HCBS and Medicaid Eligibility:

1. Child/youth enters the RTF or State PC with Medicaid
2. Child/youth enters the RTF or State PC without Medicaid and the OMH PRO determines Medicaid eligibility prior to discharge
3. Child/youth enters the RTF or State PC without Medicaid and is discharged before the OMH PRO determines Medicaid eligibility

The following outlines the process for connecting children/youth who are being discharged to a HH or C-YES for purposes of an HCBS Eligibility Determination and access to HCBS in each of the three scenarios listed above when an identified need is established.

Scenario 1: Child/youth enters the RTF or State PC with Medicaid

Children/youth who are enrolled in Medicaid prior to admission to an RTF or State PC and have an identified need for high level services will be referred to a HH for care management services and an HCBS Eligibility Determination before being discharged, when possible. The referral can be made up to 30 days prior to discharge.

- If the child/youth is already connected to HH care management agency and or HCBS, a new referral is not needed if the child/youth has been inpatient for 90 days or less. Contact with the current HH provider is needed.

HHCMs are permitted to serve a child/youth 30 days prior to discharge to assist with discharge planning, to secure services, and to establish HCBS eligibility. If a child/youth in an RTF or State PC needs HCBS in order to be safely discharged to their home and community, then the HCBS/LOC Eligibility Determination must be completed before discharge. Coordination between the RTF or State PC and the HH is necessary to ensure children/youth are safely discharged.

In circumstances when the child/youth is referred to a HH after discharge, such as when the child's length of stay is less than 30 days, or when there is a change in the child/youth's discharge plan, the child should be enrolled in a HH immediately. The HH must complete an HCBS eligibility determination within 30 days of the referral.

Scenario 2: Child/youth enters the RTF or State PC without Medicaid and the OMH Patient Resource Office (PRO) determines Medicaid Eligibility before discharge

Children/youth who are enrolled in Medicaid prior to discharge will be referred to a HH for care management services and an HCBS eligibility determination. Once Medicaid eligibility is established by OMH, the referral can be made up to 30 days prior to discharge.

Once Medicaid is established by OMH, HHCMs are permitted to serve a child/youth immediately to assist with discharge planning, to secure services, and to establish HCBS eligibility. If the RTF/State PC unable to make a referral to the HH 30 days prior to discharge, the referral should be made immediately with the information regarding the discharge date. Once the referral to HH is made (which may occur at the time of discharge), the HH will need to work with the child/youth/family and the RTF or State PC to ensure proper documentation and information is obtained to complete the HCBS/LOC Eligibility Determination.

It is imperative that the HHCM remembers that the Medicaid eligibility established by PRO under District 97 continues **only** for the month of discharge and one month after the month of discharge. The HHCM will need to ensure that HCBS/LOC eligibility is completed prior to Medicaid eligibility ending and the DOH Capacity Management is notified to enter the proper Recipient Restriction K-codes to ensure that if the Local District needs to conduct Family of One budgeting, they will be aware of the HCBS eligibility.

Scenario 3: Child/youth enters the RTF or State PC without Medicaid and the OMH Patient Resource Office (PRO) cannot determine Medicaid Eligibility before discharged

Up to 30 days prior to discharge, but no later than the date of discharge, the RTF or State PC will refer children/youth who are not already enrolled in Medicaid or cannot be determined Medicaid eligible under District 97 to C-YES for an HCBS Eligibility Determination and assistance with the Medicaid eligibility application.

Responsibilities of Each Party Involved

To ensure adequate services are available upon discharge and uninterrupted Medicaid coverage for children who may not be otherwise eligible for Medicaid, coordination is essential and the sharing of information critical for a successful transition.

RTFs/State PCs

1. Determine when a child/youth will be ready for discharge.
2. As soon as possible, up to 30 days prior to discharge, work with the family/caregiver to identify their preferred HH or HH CMA and make a direct referral. If Medicaid will not be established prior to discharge, then make a referral to C-YES.
3. At time of referral, indicate Medicaid eligibility status and potential discharge date.
4. When a HH/C-YES care manager is assigned, ensure all necessary documentation is provided and forms are complete to facilitate completion of an HCBS Eligibility Determination (i.e. Diagnosis, Disability, LPHA form, etc.).
5. Continue to work collaboratively with the HH/C-YES care manager to ensure a seamless transition to the community and access to needed services.
6. Please note: For children who are being discharged from an RTF or State PC and are in foster care, it is expected that there is enhanced collaboration with the LDSS and the Voluntary Foster Care Agency, if applicable, to ensure access to needed Medicaid services and to promote a safe and stable discharge. For children in foster care, the LDSS will enroll them in Medicaid using the foster care Medicaid rules.

OMH Patient Resource Office (PRO) and LDSS

1. For children/youth who have been determined Medicaid eligible by the OMH PRO, OMH PRO will transition the OMH Medicaid (District 97) case to the LDSS District of Fiscal Responsibility.
 - a. For SSI Medicaid eligible children/youth, PRO will transfer the OMH Medicaid coverage to the new district through the Auto-State Data Exchange (SDX) process.
 - b. For all other children/youth:
 - i. PRO will initiate the closing of the child/youth's OMH Medicaid case.
 - ii. PRO will change the child/youth's residence address to their discharge address, and a closing notice will be sent to this the discharge address. The notice will advise that the coverage will be

- transferred to the new district and will identify the effective date that the OMH Medicaid case will end.
- iii. PRO will mail a Relocation Referral Form and pertinent case information to the Medicaid Director in the new district of residence.
- iv. The Relocation Referral Form sent by the PRO will indicate whether the child is enrolled in Waiver services or that a referral has been made.
- 2. Upon receipt of the Relocation Referral Form, the LDSS District of Fiscal Responsibility (DFR) will establish uninterrupted coverage for the case, transitioning the Medicaid coverage from OMH Medicaid to the county.
- 3. LDSS District of Fiscal Responsibility (DFR) will issue the appropriate opening notice.
- 4. DOH will notify the LDSS of the approval for HCBS eligibility and enter the appropriate Recipient Restriction K-code on eMedNY to indicate participation in the Children's Waiver. This will provide necessary information to the LDSS for purposes of redetermining Medicaid eligibility for the child/youth; including the authorization to use Family of One budgeting, if necessary.

C-YES

- 1. The RTF or State PC will refer children/youth to C-YES who are not already enrolled in Medicaid or cannot be determined Medicaid eligible under District 97 for an HCBS Eligibility Determination and assistance with the Medicaid eligibility.
 - a. The assigned C-YES family support worker will contact the RTF/State PC 48 hours after they are assigned to notify the referring RTF/State PC of the assignment.
 - b. C-YES will gather the necessary information to follow up with the family prior to the discharge of the child/youth, whenever possible.
 - c. C-YES will stay in contact with the RTF/State PC staff who can assist with necessary information and the LPHA form to conduct the HCBS/LOC Eligibility Determination.
 - d. C-YES must also notify the RTF/State PC assigned OMH Patient Resource Office (PRO) when a child is determined eligible for HCBS.
 - e. When developing the person-centered POC and referring to HCBS, C-YES will notify HCBS providers that the child/youth was discharged from the RTC/State PC.
 - f. C-YES must follow their established processes in addition to the steps outlined above.

Health Home

- 2. The RTF or State PC will refer children/youth to HH who have Medicaid eligibility prior to entering care or if PROs established OMH District 97 Medicaid eligibility prior to or at discharge for an HCBS Eligibility Determination.
 - a. After verifying Medicaid eligibility, the assigned HHCM will contact the RTF/State PC 48 hours after they are assigned to notify the referring RTF/State PC of the assignment.

- b. HHCM will gather the necessary information to follow up with the family prior to the discharge of the child/youth, whenever possible.
- c. The HHCM will schedule an appointment to meet with the child/youth, family, and RTF/State PC staff to gather the necessary information to conduct the HCBS/LOC Eligibility Determination and complete appropriate consents.
- d. If the child/youth is determined HCBS eligible, the HHCM will follow the HCBS process to obtain a slot with Capacity Management and issue the appropriate Notice of Decision.
- e. The HHCM must also notify the RTF/State PC assigned OMH Patient Resource Office (PRO) when a child is determined eligible for HCBS. This notification will be made prior to the child's discharge, wherever possible, and no later than 30 days from the date of the referral.
- f. When developing the person-centered POC and referring to HCBS, the HHCM will notify HCBS providers that the child/youth is being discharged from the RTC/State PC to ensure the first appointment and services are in place after discharge, whenever possible.

APPENDIX I: HEALTH HOME SERVING CHILDREN POLICY INFORMATION

Health Home Policy Document	Description
<u>Comprehensive Assessment Policy</u>	Establishes standards and guidance regarding the Health Home comprehensive assessment that is required for all Health Home enrollees
<u>Health Home Quality Management Policy</u>	Describes the scope and required procedures for continuous quality improvement, monitoring, and oversight within the Health Home network
<u>Health Home Notices of Determination and Fair Hearing Policy</u>	Outlines the policies and procedures for issuing Notices of Determination for Health Home enrollment and the steps for requesting and attending a Fair Hearing
<u>Health Home Monitoring: Reportable Incidents Policies and Procedures</u>	Defines the requirements for Health Homes to identify, receive, investigate, resolve and record Reportable Incidents, including a continuous quality improvement process to track and identify trends to reduce risk and minimize the potential for future occurrence of the same or related incidents
<u>Health Home Plan of Care Policy</u>	Outlines standards and guidance for Plans of Care (POCs) completed by Health Home Care Managers
<u>Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents</u>	Lists the various Health Home consents requirements and policies/procedures related to PHI protections
<u>Health Home Care Management Activities and Billing Protocols for Managing Newly Referred Individuals from Excluded Settings</u>	Addresses steps that must be taken to manage new referrals from excluded settings of potentially eligible Health Home and/or HCBS children/youth
<u>Conflict Free Case Management Policy</u>	Outlines the federally guided principles of Conflict Free Case Management (CFCM) and implementation strategies for each

Appendix J: Waiver Performance Measures

The following table lists performance measures as identified in the 1915(c) Children's HCBS Waiver that are pertinent to HH/C-YES Care Managers and HCBS Providers. The performance measures noted in this appendix section are not inclusive of all performance measures and quality metrics required by the Waiver and monitored by DOH. For a full list of all required reporting measures and metrics, please see the [Waiver](#).

Performance Measure	Relevant Party	Waiver Appendix
An evaluation for LOC is provided to all applicants for whom there is a reasonable indication that services may be needed in the future. The percent of children that met initial LOC requirements prior to receiving services.	HH/C-YES Care Managers & HCBS Providers	B
The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant LOC. The percent of annual LOC forms/instruments completed as required in the approved waiver.	HH/C-YES Care Managers	B
Performance Measure: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant LOC. The percent of LOC forms/instruments completed as required in the approved waiver.	HH/C-YES Care Managers	B
Percent of waiver providers providing waiver services who meet designation, licensure, and certification requirements continuously.	HCBS Providers	C
Percent of waiver providers providing waiver services who meet designation, licensure, and certification requirements prior to furnishing waiver services initially.	HCBS Providers	C
Percent of waiver providers providing waiver services who have an active agreement with the State to provide Medicaid services if they are FFS, or an active agreement with the State to provide Medicaid services and an active agreement with the MCO if they are MC.	HCBS Providers	C
Percent of providers of waiver services who meet training requirements during the Children's Waiver re/designation process (Non-Certified/Non-Licensed).	HCBS Providers	C
Percent of providers of waiver services who meet training requirements during the Children's Waiver re/designation process (Certified/Licensed).	HCBS Providers	C
Percent of participants reviewed with a POC that contains interventions/strategies that were adequate and appropriate to their needs and goals (including health goals) as indicated in the assessment(s).	HH/C-YES Care Managers	D
Percent of participants reviewed with a POC that has adequate and appropriate strategies to address their health and safety risks as indicated in the assessment(s).	HH/C-YES Care Managers	D

Performance Measure	Relevant Party	Waiver Appendix
Percent of participants reviewed with a POC that addressed the participant's goals/needs as indicated in the assessment(s).	HH/C-YES Care Managers	D
The percent of POC forms/processes completed as required in the waiver.	HH/C-YES Care Managers	D
Percent of participants whose POC was updated within 365 days of the last POC evaluation.	HH/C-YES Care Managers	D
Percent of participants whose POC was updated as warranted by changes in the participant's needs.	HH/C-YES Care Managers	D
Percent of new participants receiving services according to their POC within 45 days of approval of their POC.	HH/C-YES Care Managers	D
Percent of participants who received services in the type, amount, duration, and frequency specified in the POC.	HH/C-YES Care Managers & HCBS Providers	D
Percent of participant records reviewed with a completed signed freedom of choice (FOC) form that specifies choice was offered among waiver services and providers.	HH/C-YES Care Managers	D
Percent of participant records reviewed with a POC that includes the participant's and/or guardian/caregiver's signature as consistent with State and Federal guidelines.	HH/C-YES Care Managers	D
Number and percent of substantiated cases of abuse, neglect, exploitation, and unexplained death where recommended actions to protect the participants health and welfare were implemented.	HH/CYES Care Managers & HCBS Providers	G
Percent of reports related to abuse, neglect, exploitation, and unexplained death of participants where an initial action to protect the health and welfare of the child or an investigation was initiated within the established timelines.	HH/C-YES Care Managers & HCBS Providers	G
Percent of waiver participants enrolled who have contact with their care manager consistent with the waiver guidelines.	HH/C-YES Care Managers & HCBS Providers	G
Percent of appeals and state fair hearings filed by participants that were resolved according to approved waiver and State guidelines.	HH/CYES Care Managers & HCBS Providers	G
Percent of participants who received information on how to report suspected abuse, neglect, exploitation, or unexplained death according to policy.	HH/C-YES Care Managers & HCBS Providers	G
Number and percent of participant incidents that were reported, reviewed, and submitted to DOH within required timeframes, as specified in the approved waiver.	HH/C-YES Care Managers & HCBS Providers	G
Number and percent of unauthorized uses of restrictive interventions, including restraints and seclusion, that were appropriately and timely reported per guidance.	HH/C-YES Care Managers & HCBS Providers	G
Number and percent of Children's Waiver participants who received annual physical exams or a wellness exam per guidelines.	HH/C-YES Care Managers	G
Percent of FFS claims paid using FFS rates that follow the rate methodology in the approved waiver application.	HCBS Providers	I

Performance Measure	Relevant Party	Waiver Appendix
Percent of claims paid only for services rendered when participants were enrolled in the waiver and eligible for such services, and when the services were provided by a qualified provider.	HCBS Providers	I
Percent of MC Children's Waiver payments paid consistent with the payment and rate methodologies in the approved waiver.	MCO/ HCBS Providers	I
Percent of FFS claims and MC encounters paid in accordance with the waiver's approved rates and methodologies.	MCO/ HCBS Providers	I

Appendix K: K-Codes RR/E for the Children's Waiver

Members enrolled in the HCBS Children's Waiver will have Recipient Restriction/Exemption (RR/E) codes, identified as "K-codes" to indicate which children/youth are enrolled in waiver services and their specific population category.

RR/E Code	R/RE Code Description
K1	HCBS LOC
K3	HCBS Serious Emotional Disturbance (SED)
K4	HCBS Medically Fragile (MF)
K5	HCBS Developmentally Disabled and Foster Care (DD & FC)
K6	HCBS Developmentally Disabled and Medically Fragile (DD & MF)
K9	Foster Care
KK	Family of One
A1	Children's Health Home: indicates the member is in outreach or enrolled with a Care Management Agency
A2	Children's Health Home: indicated the member is in outreach or enrolled with a Health Home

If an MMCP receives an HCBS claim for a child/youth whose RR/E K-code cannot be verified, the MMCP should deny the claim for lack of verification of Children's Waiver eligibility, enrollment, and approved service. Children's HCBS providers and MMCPs should coordinate with the child/youth's care manager to ensure that the appropriate K-code is on the child/youth's file and enrollment in the 1915(c) Children's Waiver is confirmed. HCBS providers should also be mindful of timely filing timeframes when submitting claims to MMCPs.

If a member's RR/E K-codes are missing or incorrect, the HCBS provider contacts the HHCM or C-YES. The HHCM or C-YES is responsible for ensuring proper Children's Waiver K-codes and will communicate any K-code issues to the DOH Capacity Management.

Appendix L: Billing and Claiming Resources

The following lists resources that HCBS providers, HHCMs, and Medicaid Managed Care Plans may find useful.

Resource	Description
NPI Number Webinar	Guides agencies through the application process for an NPI number and explains a general overview of the significance and utility of the NPI number
Medicaid Provider Enrollment for New Children's SPA and HCBS Providers	Walks through the steps providers need to take to enroll as a Medicaid provider to bill and be reimbursed by Medicaid
Understanding Paper Claims Submissions	Reviews the steps for submitting paper claims and walks through each component of the UB-04 claim form
Principles of Revenue Cycle Management and Utilization Management	Provides background information, definitions, tips/tools related to revenue cycle management and utilization management
Billing Tool	An interactive UB-04 form that walks through the components required to submit a clean claim

Appendix M: Allowable Billing Combinations

NYS Allowable Billing Combinations of Children's Behavioral Health, Children and Family Treatment and Support Services and HCBS												
HCBS	OMH Clinic	OASAS Clinic	OASAS Opioid Treatment Program	OMH Youth ACT*	OMH PROS**	OMH CDT**	OMH Partial Hospital	OASAS Outpatient Rehab	CPST/ OLP	PSR	FPSS	YPST
Day Habilitation	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Community Habilitation	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Caregiver/Family Advocacy and Support Services	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Respite	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Prevocational Services	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Supported Employment	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Palliative Care Pain & Symptom Management	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Palliative Care Counseling and Support Services	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Palliative Care Massage Therapy	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Palliative Care Expressive Therapy	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Adaptive and Assistive Technology	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

* Youth ACT has care management built in and is considered an all-inclusive program for Mental Health. As such, on-going co-enrollment with HCBS is not allowable because of the care coordination of both services **except for 30 days prior to discharge from Youth ACT.**

******These services are available to youth aged 18 and older